STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245286	A. BUILDING _____ B. WING _____	08/20/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide services in a dignified manner for 1 of 2 residents (R22), reviewed for dignity. Findings include: R22's admission Minimum Data Set (MDS), dated [DATE], identified R22 was able to make himself understood and his speech was clear. The MDS further identified R22 had [DIAGNOSES REDACTED]. During observation and interview on 8/17/20, at 5:20 p.m. R22's oxygen nasal cannula was noted taped to his face using clear plastic tape. R22 stated he taped the cannula to his face, because, It won't stay in my nose, so I tape it. R22 further stated he talked with a facility staff member on 8/16/20, about getting a mask to use instead. R22 reported he was told, 'maybe a mask will work,' but a mask was not brought in for R22 to try. During observation on 8/18/20, at 1:52 p.m. R22 was outside at an activity. Nasal cannula was secured to his nose with clear plastic, medical tape. During observation and interview on 8/18/20, at 2:17 p.m. R22 was in his room. The nasal cannula was taped to his face with clear plastic medical tape. Tape was placed under his nose and reached to each cheek, under his eyes. R22 stated, I have to go to [MEDICAL CONDITION] with this tape on my face. I'm not happy about that. I think a mask would look a lot nicer. This tape looks ridiculous. During observation and interview on 8/19/20, at 7:12 a.m. R22 was resting in bed with the nasal cannula in his nose, taped to the bridge of his nose, as well as under his nose to both lower cheeks, with clear, plastic medical tape. R22 stated he was given the tape by one of the nurses. R22 further stated he again talked with one of the facility staff, in the evening on 8/18/20, about trying an oxygen mask. R22 did not recall the name of the staff he talked with. R22 stated, They brought in a mask for the nebulizer but not for the oxygen. R22 stated the response to his request was, 'I don't know if we have any.' R22 stated I think a mask would look a lot nicer, but I have to keep this in my nose so I need to do something. During observation on 8/19/20, at 9:18 a.m. R22's nasal cannula remained taped across the bridge and under his nose, and across both cheeks, with clear plastic medical tape. R22 was brought out of his room and to the entrance of the facility to leave for an appointment. R22 left the facility with nasal cannula taped to his face. During observation on 8/20/20, at 8:27 a.m. R22's nasal cannula tubing was around his ears with gray foam protectors. The oxygen tubing was under R22's nose, with white paper tape securing it over the bridge of his nose, and the edges of the tape were loose and peeling up. Clear, plastic medical tape was observed across the bottom of his nose to above both cheek bones, the edges of the tape were loose. During interview on 8/20/20, at 8:42 a.m. registered nurse (RN)-A stated R22 taped the nasal cannula himself, because, He thinks it stays in there better. RN-A stated she talked with R22 about a face mask on 8/19/20, and stated, I explained he could do the facemask, but he said he would want to take it off to eat. RN-A further stated R22 had not asked RN-A about a mask before that conversation. RN-A confirmed the tape does not look good and does not look dignified and stated, I wouldn't want to look like that. During interview on 8/20/20, at 10:11 a.m. director of nursing (DON) stated, He is the one that requests to put it there because his nasal cannula won't stay in. DON confirmed the tape makes him feel undignified. Facility policy for dignity requested but was not provided.
F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a written notification of transfer was provided for 1 of 2 residents (R22) upon transfer to the hospital. This had the potential to affect all residents transfers. In addition, the facility failed to notify the Ombudsman for Long Term Care of resident's transfer to the hospital for 1 of 2 residents (R22), reviewed for hospitalization . Findings include: R22's face sheet printed 8/20/20, indicated R22 [DIAGNOSES REDACTED]. Progress notes dated 6/27/20, indicated an on call doctor was updated by facility licensed staff when R22 complained of loss of appetite and could not eat his food. Licensed staff assessment include the following findings: temperature 100.7 F, blood pressure 108/64, pulse 106, oxygen saturation 82% (oxygen level in blood), respirations 18, and lung sounds wheezes bilaterally. The progress noted further noted that R22 was sent to the hospital as advised by the on call doctor. Progress note dated 6/28/20 indicated R22 was admitted to the hospital for pneumonia and stable [MEDICAL CONDITION]. R22's medical record lacked evidence of notification of the Ombudsman of R22's transfer to the hospital. During interview on 8/19/20, at 3:15 p.m. licensed social worker (LSW)-A stated a fax was typically sent monthly to the Ombudsman with information of facility initiated resident transfers and discharges. LSW-A further stated the information sent included information of residents sent to and/or admitted to the hospital. The facility's Monthly Notice to MN Office of Ombudsman for Long-Term Care of Emergency Acute Care Transfers and Discharges, dated June 2020, was reviewed. R22's name was not noted on this form. LSW-A confirmed these findings, stating, Obviously it got missed if I didn't write it down. During interview on 8/20/20, at 8:31 a.m. director of nursing (DON) stated she was not sure of the notification of reason for transfer or the notification sent to the Ombudsman and needed to defer those questions to the social worker. During interview on 8/20/20, at 8:42 a.m. registered nurse (RN)-A stated written notification was not usually sent to the resident's representative, but was usually communicated to the representative by phone. RN-A further stated the information provided by phone included the information for the reason the resident was transferred. R22's Progress note dated 6/27/20 lacked further evidence that R22 or R22's representative received a phone call or written notification of the reason for transfer. A facility policy regarding required notification with transfer/discharges was requested but not provided.
F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 1 of 2 residents (R22), reviewed for hospitalization s. Findings include: R22's face sheet printed 8/20/20, indicated R22's [DIAGNOSES REDACTED]. R22's progress note dated 7/14/20, indicated R22 was transferred to the hospital due to chest x-ray findings of a rib fracture. R22's progress note dated 7/20/20, at 3:53 p.m. indicated R22 was readmitted to the facility. Review of R22's clinical record, including progress notes, lacked evidence that neither R22 nor R22's representative were informed of the bed hold policy at the time of hospitalization . During interview on 8/19/20, at 3:15 p.m. social worker (SW)-A stated the normal process was to provide the bed hold policy and to send the copy of the bed hold with the resident. During interview on 8/20/20, at 8:11

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

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

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F 0625 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	(continued... from page 1) a.m. SW-A stated a bed hold probably wasn't done because the facility thought he was going to the emergency room then coming right back. SW-A further stated R22 was not called to ask about the bed hold because SW-A was not aware of where he transferred to. SW-A stated she would normally have done the bed hold. During interview on 8/20/20, at 8:31 a.m. director of nursing (DON) stated the bed hold was signed by the resident if they left the facility and were able to sign, otherwise a verbal agreement was received. DON stated the bed hold was obtained by the nurse on duty or the social worker, if available. A facility policy regarding the bed hold policy was requested, but was not received.
F 0636 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure complete and comprehensive Minimum Data Set (MDS) were completed for 2 of 6 residents (R14, R22) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2017, identified the MDS as an assessment tool which facilities are required to use. The manual directed comprehensive assessments, include the completion of both the MDS and the CAA (care area assessment) process, as well as care planning. Further, the manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: Section M1030 Skin wounds and [MEDICAL CONDITION] affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes . Steps for Assessment: 1. review the medical record, including skin care flow sheet or other skin tracking form. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any venous or arterial ulcers are present. Section M1040 Skin wounds and [MEDICAL CONDITION] affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes . Steps for Assessment: 1. review the medical record, including skin care flow sheet or other skin tracking form. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present. R14's Admission comprehensive assessment dated [DATE], had a check mark in the box to indicate the presence of a rash on R14's left leg, which per family's report, had been there 30+ years. R14's admission MDS, dated [DATE], section M1030 had a 0 in the box to enter the total number of venous and arterial ulcers present. Further, M1040 had an X in the box for none of the above as the answer to other ulcers, wounds, and skin problems, During an observation on 8/17/20, at 1:24 p.m. R14 revealed a wound on the left shin area about the size of a quarter with a whitish scab and a drainage spot the size of a pin head on the sock. R14 stated nursing did not do any cares for the wound because it had been there for 30+ years and had not changed. During an interview on 8/20/20, at 9:35 a.m. RN-B confirmed that she had completed R14's initial skin assessment and recalled a rash on the left shin. During an interview on 8/20/20, at 11:07 a.m. MDS coordinator (RN-C) stated information to complete the MDS was gathered through the electronic health record, nurses notes, and wound documentation. RN-C confirmed documentation upon admission of a rash on R14's left shin and that there were no wound assessments completed for R14 since admission, until the day prior. R22's admission MDS, dated [DATE], identified R22 was cognitively intact. The MDS further identified R22 was at risk for pressure ulcers/injuries. However, the MDS indicated R22 did not have any unhealed pressure ulcers. During interview on 8/20/20, at 8:42 a.m. RN-A stated R22's skin was not intact and that R22 had wounds on his left great toe since admission. During interview on 8/20/20, at 9:27 a.m. RN-B confirmed R22 had four wounds on his left great toe. RN-B further confirmed each of these areas were likely caused by pressure. During interview on 8/20/20, at 12:31 p.m. RN-C verified R22's admission MDS did not indicate pressure ulcers. RN-C stated she was not aware of the wounds because they were not noted in the progress notes or admission assessments. During interview on 8/20/20, at 12:37 p.m. DON confirmed R22's admission MDS failed to identify R22 had any pressure ulcers. Review of the facility's policy, MDS-Minimum Data Set for Nursing Facility Residents' Assessment and Care Planning, dated 7/97, included input and assistance with completing the form shall be obtained from direct-care staff.
F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide meaningful activities for 1 of 1 residents (R5), dependent on staff for activities. Findings include: R5's [DIAGNOSES REDACTED]. R5's Care Area Assessment (CAA) dated 5/18/20, indicated a potential problem for cognitive loss/dementia related to [DIAGNOSES REDACTED]. Leisure interests were cards/other games, exercise/sports, music, reading/writing, watching TV, and talking or conversing. Focusing of programming indicated 1:1 activities, independent activities, outdoor activities, relaxation activities, social interaction activities, and other- ride in the country and bingo. Activity progress note indicated R5 was starting to play hallway bingo, one to one visits two times per week, and was given the daily newsletter along with the weekly Morrison County Record. R5's interests included reading the news and visiting with others. The Activity Assessment progress note further indicated to provide R5 with daily newsletter and to encourage activities of interest. R5's care plan, dated 8/17/20, indicated R5 had a variety of interests that included country music, cards, dice, bingo, outdoor activities and visiting with others. Goals for R5 included, R5 would participate in activities of his interest including playing cards, outdoor activity, dice, and bingo two to three times per week in the next three months. Interventions included adapt programs (bingo)/ provide in hallways, encourage resident to take part in activities of his interest, and provide one to one visits. R5's care plan also indicated he had an altered mood state related to [DIAGNOSES REDACTED]. Goals for R5 included to involve in activities of interest. R5's Activity Participation Record from May through August of 2020 lacked evidence that R5 was offered activities of interest as indicated on R5's plan of care. Further, in May, R5 was offered bingo 11 days out of 31, June, was offered 13 days out of 30, July and August lacked evidence that R5 was offered bingo on any day. Resident Bingo list that was posted on bulletin boards of both south wings lacked evidence of R5 being invited to bingo on all seven days of the week evidenced by R5's name not being included on the list. During observations on 8/18/20, at 12:55 p.m. through 1:46 p.m. R5 was sitting in his room, in his recliner, with TV off. Activity calendar indicated Bingo at 1:30 p.m. During observations on 8/18/20, at 1:46 p.m. staff offered R5 to go outside and husk corn, but did not offer the choice between attending bingo or outdoor activity. During observations on 8/18/20, at 2:20 p.m. through 4:30 p.m. R5 was sitting in his room, in his recliner, light off, and TV off. Activity calendar indicated dice/horse race at 4:15 p.m. Further, activity staff started activity at 4:12 p.m. and staff did not offer resident to participate in dice/horse race activity. During interviews on 8/19/20, at 11:57 p.m. activity coordinator (AC) stated R5 enjoyed outdoor activities, cards, and Bingo. Further, AC stated R5 had been more quiet and had daily pop- in visits. AC confirmed R5 has not been getting daily newsletter due to her copier being broken and further stated she could use a different copier. AC confirmed R5 was not on Bingo invite list and stated she will assure R5 gets invited and involved more. Further, AC confirmed R5's activity logs were blank for Bingo in 8/20 and there were no marks of any refusals. AC stated that Bingo was offered in resident rooms everyday, but just recently started with group activities again. AC stated her expectation would be for staff to ask R5 if he would like to participate in the activities, especially those of R5's interests listed. During interviews on 8/19/20, at 12:35 p.m. DON stated her expectation of staff would be to offer R5 his favorite activities based off his preferences and staff should be following his care plan. Review of the facility Activity policy, dated 3/02, indicated the activity coordinator plans and organizes a program of activities for residents on a group level and for individuals. Residents shall be encouraged, but not forced, to participate in activities. Further, ambulatory resident may walk to and from activities or be assisted as needed. Non ambulatory residents will be encouraged to attend activities independently or will be assisted as needed.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a treatment was provided for a non-pressure skin wound, for 1 of 1 residents (R14), reviewed for non-pressure skin concerns. Findings include: R14's

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) quarterly Minimum Data Set (MDS), dated [DATE], indicated cognitive impairment, and R14 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. R14 had [DIAGNOSES REDACTED]. R14's care plan, last revised 6/5/20, indicated R14 was no longer able to care for self at home and had low to no risk for pressure ulcers. Interventions included assist of one staff for dressing, daily skin inspection by nursing assistants, to apply compression stockings each morning and off at bedtime, and assistance for baths or shower on Friday. During an observation on 8/17/20, at 1:24 p.m. R14 revealed a wound on the left shin area, approximately the size of a quarter, with a whitish scab and a drainage spot the size of a pin head on the sock. Further, R14 stated nursing did not do any cares for the wound because it had been there for 30+ years and had not changed. During an interview on 8/19/20, at 7:13 a.m. trained medication aid (TMA)-C stated R14 was an early riser, mostly independent, and usually had her compression socks on prior to TMA entering R14's room. TMA-C stated she became aware of R14's wound a couple weeks prior and had reported it to registered nurse (RN)-A. During an interview on 8/19/20, at 12:33 p.m. RN-A stated awareness of a scabbed area on R14's left shin and stated there were no current orders for a dressing change or monitoring for the wound, other than a full skin assessment that was completed on bath days. During an interview on 8/19/20, at 12:57 p.m. director of nursing (DON) confirmed the R14's clinical record lacked evidence that R14 had a wound on her left shin, however, at 1:06 p.m. DON confirmed the presence of a wound on R14's left shin. DON stated it was her expectation that staff should have noted R14's wound during the weekly skin checks and would at least be doing a dressing change and monitoring. During an interview on 8/20/20, at 9:35 a.m. RN-B confirmed she had completed R14's initial skin assessment and recalled a rash on the left shin. RN-B stated she was unaware of any current skin issues. During an interview on 8/20/20, at 11:07 a.m. MDS coordinator (RN-C) confirmed documentation upon admission of a rash on R14's left shin and that there were no wound assessments completed for R14 since admission, until the day prior. During an interview on 8/20/20 at 12:27 p.m. licensed practical nurse (LPN)-A stated she completed skin checks when residents were in the bathtub, but the bath aid would indicate if there were any concerns, and wounds were charted. LPN-A did not know if R14 had any wounds. Review of the facility policy, Wound Rounds, revised 1/15, stated resident wounds should be measured to show progress on a weekly basis to assure it continues to heal and to promote quality of life.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to appropriately assess, monitor, implement interventions, and document skin conditions for a pressure ulcer for 1 of 2 residents (R22). Findings include: R22's admission Minimum Data Set ((MDS) dated [DATE], identified R22 was able to make himself understood and his speech was clear. The MDS further identified R22 had [DIAGNOSES REDACTED]. R22's admission MDS failed to identify that R22 had a pressure ulcer/injury (bed sore). The MDS indicated a formal assessment instrument/tool was completed and used to complete the MDS and that R22 was at risk for pressure ulcer/injury. R22's admission skin assessment, dated 6/19/20 failed to indicate a wound was noted by the assessing nurse upon admission. R22's skin assessment upon hospital return, dated 7/20/20, identified, necrotic (dead tissue) area on Lt (left) grt (great) toe. R22's progress notes, dated 6/19/20-8/20/20, failed to identify the wound on R22's left toe, and failed to identify if R22's primary physician or if a nurse practitioner had been updated regarding the wound on R22's left great toe. R22's weekly skin checks failed to identify new or worsening skin concerns, including the area on R22's left great toe. R22's care plan, dated 6/22/20, and revised 8/3/20, indicated R22 was at low risk for pressure ulcers as evidenced by Braden Scale (used to determine risk for pressure ulcer/injury). Interventions included daily skin inspections by nursing assistants (NA), float heels off of bed, and turn and reposition every two hours. R22's treatment order, dated 7/20/20, included, clean left great toe with NS (normal saline) pat dry, then swab with [MEDICATION NAME] daily and allow to dry. Keep clean dry and intact. During interview on 8/17/20, at 5:09 p.m. R22 reported a black spot on the top of his left big toe. R22 reported the black spot was present when he admitted to this facility, I don't know when it happened. I think it was before I came here. R22 further stated the areas were treated by facility staff on a daily basis. During observation on 8/19/20, at 7:23 a.m. registered nurse (RN)-A completed treatment on R22's left great toe as ordered by his physician. Observation of the left great toe, revealed the following: four areas of eschar (area of dead tissue), one above toenail at top of toe that was smaller than a dime; one area to the right of toenail; one to the left of the toenail and one on the underside of the toe. There was no swelling or redness. R22 offered complaints of pain when area was touched and when swabbed with iodine, and reported pain as, Not too bad, but I can feel it. During interview on 8/20/20, at 8:42 a.m. RN-A stated the process at admission included a skin assessment by a registered nurse. If concerns with skin were found, then a nursing treatment was put in the computer for the area to be monitored. If size, shape, color needed to be documented in wound rounds, then it would be. RN-A stated, (R22) skin is not intact, not his toe. He's had the black spot on his left toe since he admitted to this facility, and indicated not being sure what caused the area on his left great toe. RN-A further stated, R22 received a weekly skin check that was completed by a nurse. RN-A confirmed weekly skin checks failed to identify the wound on R22's left great toe. RN-A further confirmed there were no measurements of the wound on R22's left great toe, in the skin assessments or skin checks. RN-A stated she was not able to determine if the wound on R22's left great toe had improved or worsened since admission due the lack of documentation, including measurements. RN-A stated she had been monitoring the wound since admission and thought it looked the same as it did when R22 admitted to the facility. During interview on 8/20/20, at 9:10 a.m. RN-B stated the process for treatments performed on wounds that are not pressure related, are completed by either licensed practical nurse (LPN) or RN. If the nurse who completed the treatment had questions or concerns regarding the wound, they would talk with RN-B or update a nurse practitioner. RN-B reported the RN who completed the admission assessment would determine if the resident had a pressure ulcer and wound rounds were completed weekly for residents identified to have a pressure ulcer. RN-B stated she was one of the nurses assigned to complete wound rounds and stated she was not aware of the wound on R22's left great toe. RN-B further confirmed R22's medical record, including progress notes and assessments failed to identify a pressure ulcer. During observation and interview on 8/20/20, at 9:27 a.m. RN-B assessed R22's left great toe. RN-B reported her findings as: necrotic area on tip of toe and on side. No redness. No signs or symptoms of infection. Areas around wounds were blanchable (when skin becomes white or pale when slight pressure is applied). RN-B measured two of the wounds and stated the following measurements: tip of toe-1.4 centimeters (cm) x 1.5 cm, no measurable depth, no drainage; underside of toe- 0.6 cm x 0.7 cm, no measurable depth, no drainage. RN-B stated the other two necrotic areas are similar in size to the second area she measured. RN-B assessed wound to be pressure related and unstageable (severity cannot be determined). R22 stated he had pain in the toe when it was touched, however, declined to see a physician when offered by RN-B. RN-B confirmed presence of pressure ulcer on R22's left great toe and indicated the wound should have been identified upon admission. RN-B stated R22's left great toe should have been monitored on weekly wound rounds, starting at time of admission. During interview on 8/20/20, at 10:11 a.m. director of nursing (DON) stated skin assessments were completed on the day of admission by the RN Case Manager and included a full head-to-toe skin assessment, and the nurse manager determined if noted skin concerns were related to pressure. DON stated weekly skin checks were completed by LPN's on the residents' bath day. The nurse manager completed weekly wound rounds for pressure ulcers. Documentation of pressure ulcers included measurements, length, width, and depth, presence of drainage, appearance of wound, including wound bed and staging (stage I-IV, depending on severity of wound). DON verified there was no documentation of R22's left great toe wound on his admission skin assessment. The facility's pressure ulcer policy was requested but not received.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to secure 1 of 1 residents (R21) with a safety belt while in the tub chair. This resulted in actual harm when R21 fell from the bath chair and sustained a nasal fracture and laceration to the bridge of his nose and required five stitches. Prior to this survey the facility had implemented corrective action on 3/17/20. The deficient practice is being issued as past non-compliance. Findings include: R21's quarterly Minimum Data Set ((MDS) dated [DATE], identified R21 had severe cognitive impairment and had [DIAGNOSES REDACTED]. The MDS indicated R21 was dependent with transfers and bathing tasks, and required extensive assistance with all other activities of daily living (ADLs). The MDS identified R21 had no falls since the prior assessment and identified R21's transfer balance was not steady and only able to stabilize with human assistance. R21's annual Care Area Assessment

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) (CAA) dated 12/24/19, identified R21 had cognitive loss due to [MEDICAL CONDITION] and required assist of two with bed mobility, transfers, toileting, and dressing. The CAA indicated R21 required assist of one with locomotion, personal hygiene and bathing. R21's care plan, revised 7/9/20, identified R21 had cognitive loss related to [MEDICAL CONDITION] and required assist of two with a Hoyer (mechanical lift used to transfer immobile residents) to transfer. The care plan instructed staff to use two staff to transfer R21 to the tub chair and to use the safety belt on R21 when in the tub chair. The care plan identified R21 was at risk for falls due to limited mobility secondary to [MEDICAL CONDITION]. Review of R21's event report dated 3/12/20, indicated R21 fell face first out of the tub lift chair in his room due to staff not applying the safety belt. R21 developed a triangular shaped cut across his nose and a cut between his eyes. R21 was noted to be face down in a large pool of blood and staff turned him to his back due to the bleeding and R21 being unable to breathe properly. Staff applied pressure to stop the bleeding and called 911. R21 was transferred to the local hospital for treatment. The post fall summary of the event report identified R21 fell out of the chair due to staff not applying the safety belt. Education was immediately provided to the staff involved, signs posted and the rest of the staff were educated on the importance of using the safety belt. Review of R21's progress notes from 3/12/20, to 8/19/20, revealed the following: - 3/12/20, at 8:11 a.m. staff reported they needed assistance as R21 was bleeding everywhere. R21 had a large pool of blood next to him and staff were noted to be applying pressure to R21's nose to stop the bleeding from the V-shaped laceration present on R21's bridge of his nose. Additionally, R21 had a small laceration between his brows. R21's right cheek and eye swelled up and pupils were noted to be sluggish. R21 was assisted off the floor to the ambulance cot with the Hoyer lift and assistance of four staff. - 3/12/20, at 8:55 a.m. R21 fell face first out of the tub chair and landed on his face and had a triangular shaped cut across his nose, a laceration between his eyes and a large pool of blood underneath his face. Two NA's were present in the room at the time of the fall. Staff held R21's neck and turned R21 onto his back due to the bleeding and inability for R21 to breathe properly. Staff applied pressure and a NA called the ambulance. Staff noted bruising starting to form to R21's knees. R21 was transferred via ambulance to the local hospital. - 3/12/20, at 12:49 p.m. R21 returned from the hospital with orders of [MEDICATION NAME] (an antibiotic) 100 mg. (milligrams) twice daily and a nasal spray two to three sprays twice daily for three days. - 3/12/20, at 10:10 p.m. R21 had bruising and swelling under his left eye, his nose and on his forehead. The stitches present on R21's nose remained clean dry and intact. R21 remained in bed all shift, appeared weaker than usual and refused to eat supper. - 3/13/20, at 1:43 a.m. R21 continued to have bruising and swelling under his left eye and stitches were noted to be clean dry and intact. - 3/13/20, at 12:07 p.m. R21 was seen by medical doctor (MD) for follow-up after the fall. - 3/13/20, at 6:43 p.m. bruising and swelling noted under R21's left eye and bruising noted to R21's forehead. - 3/14/20, at 12:02 p.m. swelling continued to be noted under both R21's eyes and nose. Dark purple bruising under R21's left eye remained and the stitches to R21's nose laceration were clean dry and intact. - 3/15/20, at 1:20 a.m. slight bruising noted under R21's eyes and swelling remained to R21's bridge of his nose and under his eyes. - 3/15/20, at 10:19 p.m. stitches remained intact and bruising remained under R21's right eye. - 3/17/20, R21 had appointment with ear nose and throat (ENT) MD (medical doctor) and sutures were removed from R21's laceration and the nasal fracture was noted to be in good position with no surgery required. Review of MD progress notes from 3/12/20, to 3/17/20, revealed the following: - 3/12/20- emergency department (ED) progress notes indicated R21 presented to the ED after a fall. R21 was noted to have [MEDICAL CONDITION], was on [MEDICATION NAME] (a blood thinner) and occasionally had falls. R21 fell face first, hit his nose and had significant blood noted from his nose. CT (computerized tomography) scan was completed of the head, facial bones and neck and revealed a comminuted fracture (A comminuted fracture is a break or splinter of the bone into more than two fragments. Since considerable force and energy is required to fragment bone, fractures of this degree occur after high-impact trauma) of the nasal bone with deviation to the right. R21 received five sutures to the laceration to the nose he obtained from the fall. R21 was sent back to the facility on antibiotics and a nasal spray with plans to follow-up with the ENT MD sometime in the next week. - 3/13/20, family medicine progress note indicated R21 was seen for a follow-up ED (emergency department) visit. On 3/12/20, R21 fell and hit his face on the floor and sustained a displaced [MEDICAL CONDITION] bone and a laceration to his nose. Plan to continue antibiotics, follow-up with ENT and to have sutures removed in five to seven days. - 3/17/20, ENT progress note indicated R21's sutures were removed from the nasal laceration and the nasal fracture was in good position. Review of the CT of the head results on 3/12/20, revealed a comminuted [MEDICAL CONDITION] bone with mild deviation to the right. Review of R21's MD current orders revealed R21 was on [MEDICATION NAME] 5 mg five days a week and received [MEDICATION NAME] 7.5 mg. two days a week. During observation on 8/19/20, at 9:07 a.m. R21 was seated in his wheelchair while nursing assistant (NA)-A and NA-B applied the loops from the lift sling to the Hoyer lift. NA-A operated the Hoyer lift to lift R21 up out of wheelchair while NA-B guided R21 to the bed. NA-A lowered R21 down in the bed and with NA-B's assistance removed the sling from underneath R21 while rolling him back and forth in bed. NA-B removed R21's incontinence brief, provided peri cares and applied a fresh brief. NA-A removed R21's shoes, covered R21 with a blanket and clipped his call light to his bed within his reach. NA-A and NA-B removed their gloves and completed hand hygiene. R21 had non-skid strips next to his bed and in his bathroom. On 8/19/20, at 9:14 a.m. NA-B stated R21 required total assistance with all cares and a Hoyer lift was used for transfers. NA-B stated R21 received a tub bath twice a week, indicated two staff transferred R21 onto the tub chair and stated staff were expected to apply the safety belt around R21's waist when he was in the chair to prevent falls. NA-B stated R21 did have a fall from the tub chair a few months ago and R21 required stitches to his nose. On 8/19/20, at 10:41 a.m. NA-C stated she worked five days a week as the bath aid for the facility. NA-C stated R21 received a tub bath two days a week on Mondays and Thursdays and indicated he was totally dependent on staff for transfers onto the tub chair and for bathing tasks. NA-C stated it was an expectation the staff apply the safety belt to R21 when he was in the tub chair. NA-C stated she was aware R21 had a fall from the tub chair a few months back after staff had not applied the safety strap and he required a trip to the hospital as a result of the fall. On 8/19/20, at 10:49 a.m. registered nurse case manager (RN)-A confirmed R21 had a fall from the tub chair a few months ago when staff had not applied the safety belt and broke his nose. RN-A confirmed R21 was not able to hold himself up in the tub chair due to [MEDICAL CONDITION] and indicated the safety belt should have been applied at all times. RN-A reviewed R21's electronic health record (EHR) and stated on 3/12/20, R21 had a nasal fracture and had stitches to the bridge of his nose as a result of the fall from the tub chair. RN-A stated all staff received education and signs were posted to remind staff to apply the safety belt when R21 and other residents were in the tub chair. On 8/19/20, at 11:27 a.m. NA-D stated R21 required total assistance from staff with most ADLs and he tended to lean forward when up in the tub chair. NA-D stated on 3/12/20, she was wheeling R21 in the tub chair to the doorway of his room to bring him to the tub room for his bath when R21 fell forward from the tub chair, landed on his face and started to bleed. NA-D confirmed staff had not applied the safety belt to R21 prior to his fall. NA-D stated the nurse was notified, provided first aid to R21 and R21 was sent to the hospital for treatment. NA-D stated R21 received a cut from the fall and indicated she received immediate education on the use of the safety belt when R21 and other residents were up in the tub chair. On 8/19/20, at 11:35 a.m. director of nursing (DON) stated it was expected staff applied the safety belt for all tub chair transfers. DON confirmed R21 had a fall on 3/12/20, from the tub chair due to staff not applying the safety belt to R21. DON confirmed R21 was sent to the ED and was diagnosed with [REDACTED]. DON stated immediate education occurred to the staff involved in the incident and reminder signs were placed in both tub rooms of the need to use the safety belt. DON stated all nursing staff were educated on the use of the safety belt beginning that same morning and was completed by the time the incident report was closed on 3/17/20. DON stated R21's care plan was updated on 3/17/20, to instruct staff to apply the safety belt as soon as R21 was up in the tub chair. DON stated audits of the use of safety belts had been completed and no further issues were identified. Review of the manufacturer's instructions titled System Preparation (Before Transferring of Lifting), undated, instructed staff to route the belt through the belt loops of the chair frame prior to placing the resident into the chair. After the resident is transferred to the chair, staff were instructed to bring the seat belt around the resident to be connected. Review of facility policy, Baths, dated 7/01, instructed staff to assist resident into the tub chair and secure the safety straps. Review of the employee files revealed both NA's that assisted R21 on the day of the fall had been trained in the use of the safety belt for tub baths upon hire. The past non-compliance that began on 3/12/20, was verified during the 8/20/20, onsite visit and was corrected by the facility on 3/17/20. The verification of corrective action was confirmed by interview with a variety of nursing staff, residents and observation of residents who received tub baths, in addition to documentation of education provided to the nursing staff. On 3/12/20, immediate education was provided to the staff involved. R21's care plan was revised and education was completed for the majority of the remaining nursing staff by 3/17/20. Additionally, reminder signs were posted in both of the tub rooms in the facility and audits were completed to ensure staff compliance with the use of the

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	245286	A. BUILDING _____ B. WING _____	08/20/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) safety belt.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure proper placement and storage of catheter drainage bag was provided, in a manner to prevent potential for infections for 1 of 1 resident (R24), reviewed for catheter care. Findings include: R24's admission Minimum Data Set (MDS), dated [DATE], identified R24 had moderate cognitive impairment and required assistance from one staff for bed mobility, transfers, ambulation, dressing, personal hygiene, bathing, and toilet use. In addition, R24's MDS identified [DIAGNOSES REDACTED]. R24's care plan, dated 7/2/20, directed catheter cares twice daily and as needed, to change the catheter as ordered by the physician and according to Centers for Disease Control recommendations, to change the drainage bag weekly, to cover the urinary collection bag, and to keep the drainage bag below the level of the bladder. Review of R24's progress notes did not indicate R24 was non-compliant with placement of catheter collection/drainage bag. During observation and interview on 8/17/20, at 4:47 p.m. R24 was seated in his wheelchair in his room. The urine collection bag was covered inside another bag and was hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh. R24 stated, They were looking at my chair to find a place to hang it under the chair but they didn't find anything that would work, and stated the collection bag was always hanging where it was noted at time of this observation. During observation on 8/18/20, at 12:49 p.m. R24 was seated in his wheelchair in his room. The urine collection bag was hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh. The collection bag was covered by a bandana tied to the wheelchair. During observation on 8/18/20, at 12:55 p.m. nursing assistant (NA)-E emptied R24's urine collection bag. After the bag was emptied, NA-E placed the collection bag so it hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh. NA-E covered the collection bag with the bandana. During observation on 8/19/20, at 7:52 a.m. R24 was seated in his wheelchair in the dining room. The urine collection bag hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh and was covered with a bandana. The catheter tubing was noted to come out of bottom of R24's pant leg then extend up to the top of the urine collection bag. During observation on 8/19/20, at 8:59 a.m. R24 was ambulating in the hallway with staff. Urine collection bag was stored in a bag attached to the cross bars under R24's wheelchair. During interview on 8/19/20, at 9:09 a.m. R24 stated he didn't know why the urine collection bag was hanging under his chair. They said they moved it because they don't like to see it on the side of the chair. During observation on 8/19/20, at 11:39 a.m. R24 was seated in his wheelchair in his room. The urine collection bag was hung from R24's wheelchair, on the left side, on the frame located above the large side wheel. The collection bag was noted at the same level as R24's thigh and was not covered. During interview on 8/19/20, at 11:42 a.m. NA-B stated she wasn't sure how the urine collection bag got placed on the side of his wheelchair. It's supposed to be under his chair. During interview on 8/19/20, at 11:47 a.m. NA-D stated R24 was mostly independent with cares, except catheter care, perineal care (cleaning the private areas), and cleaning R24's underarms. NA-D further stated she was just in R24's room and put the urine collection bag in the storage bag hanging from the cross bars under the wheelchair. It is supposed to be under his chair. During interview on 8/20/20, at 9:57 a.m. registered nurse (RN)-A stated, I try to encourage him to keep it (urine collection bag) below his wheelchair. He always puts it back up on the armrest because it is where he likes it. I try to explain it drains better. RN-A further stated, staff would be putting it back under R24's wheelchair or educating R24 when they notice it is on the side of R24's wheelchair or they should tell her about it and she would take care of it. RN-A confirmed, if the urine collection bag is not stored below the level of the bladder, the urine will not drain and may result in urinary tract infections. RN-A confirmed further that staff should be making attempts to put the urine drainage bag under R24's wheelchair so it can drain properly. During interview on 8/20/20 at 10:03 a.m. director of nursing (DON) stated the expectation is that the urine collection bag is hung from the bed frame, below the level of bladder, when R24 is in bed and below the seat of the wheelchair, in a bag, to ensure it is below the level of the bladder, for gravity flow. DON confirmed, if the urine collection bag is not kept below the level of the bladder, it may cause the urine to back flow into the bladder which could cause an infection. DON stated further, It (urine collection bag) should be under the chair. Staff should follow the care plan. DON confirmed, R24's care plan stated to keep drainage bag below level of bladder. DON stated she would expect staff to educate R24 with reason for urine collection bag to go under the wheelchair when it noted to be on the side of the wheelchair. Review of the facility policy, Catheter. Care of Indwelling. Suprapubic, dated 12/95 indicated, Observe drainage bag position; must never touch the floor and always kept below the level of the bladder.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure medication was labeled properly for 1 of 1 resident (R14) reviewed for medications at the bedside. In addition, the facility failed to ensure medications available for use in the South medication cart, was appropriately labeled with an opened date for 1 of 1 residents (R10) reviewed for medication storage. Findings include: R14's quarterly Minimum Data Set ((MDS) dated [DATE], indicated moderate cognitive impairment and had [DIAGNOSES REDACTED]. R14's physician orders printed on 8/19/20 included [MEDICATION NAME] cream 0.5% (used to treat skin inflammation), with directions to apply thin layer to affected areas(s) twice daily as needed. During an observation on 8/17/20, at 1:24 p.m. R14 revealed a wound on the left shin area about the size of a quarter with a whitish scab and a drainage spot on the sock that was about the size of a pinhead. R14 produced a tube of ointment which she stated she routinely applied. The tube lacked a prescription label. During an interview on 8/19/20, at 12:57 p.m. director of nursing (DON) confirmed R14 had a wound on her left shin and possessed a tube of ointment which lacked an order and appropriate labeling. DON presented the ointment tube to registered nurse (RN)-A, who also denied awareness of the ointment. DON stated R14 lacked an order, appropriate labeling and assessment for self administration. DON removed the ointment from R14's possession until further evaluation could be completed. Review of the facility's Medication Labeling policy, revised 6/2018, included, F. Over-the-counter meds brought in by residents may be used if in the original unopened container-labeled as below: -Resident's Name -Date received -Direction for use from the doctor. R10's quarterly MDS dated [DATE], R10's [DIAGNOSES REDACTED]. R10's physician orders include Latanoprost ophthalmic (eye) drops, instill one drop into left eye every evening and [MEDICATION NAME] 50 mcg, instill one spray into each nostril daily. During inspection of the South medication cart on 8/17/20, at 5:30 p.m. with registered nurse (RN)-B, R10's Latanprost ophthalmic (eye) drops were opened, in the cart. There was no opened date on the medication bottle or the prescription bottle the medication was stored in. According to the pharmacy labe on the Latanoprost, this medication was filled by the pharmacy on 7/22/20. R10's [MEDICATION NAME], a nasal spray, had an opened date on the medication bottle as well as on the box the medication is stored it. The opened date, handwritten on the medication package and medication bottle, was 4/6. During interview on 8/17/20, at time of medication cart inspection, RN-B stated medications such as ophthalmic drops and nasal sprays were to be labeled with the opened date. RN-B further stated [MEDICATION NAME] should have been discarded six weeks after the medication was opened. RN-B confirmed the ophthalmic drops were opened but not labeled and the [MEDICATION NAME] was labeled with an opened date, but was past the timeline for safe administration of 6 weeks. During interview on 8/19/20, at 2:13 p.m. director of nursing (DON) stated ophthalmic drops and nasal sprays are expected to be dated with opened date, when the medication is opened. DON further stated, They should be checking their med carts and expiration dates. Review of the facility policy, Medication Labeling, dated 6/18, did not address the need to date ophthalmic drops or nasal sprays with opened date. Review of the facility policy, Eye Drops, dated 9/18, indicated Latanoprost must be dated upon opening and needed to be discarded six weeks after opening. A request for the facility

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) policy regarding nasal sprays was requested, but was not received.