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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 342Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00644

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245426**

2.STATE VENDOR OR MEDICAID NO.
(L2) **046492200**

3. NAME AND ADDRESS OF FACILITY
(L3) **KODA LIVING COMMUNITY**
(L4) **2255 30TH STREET NW**
(L5) **OWATONNA, MN** (L6) **55060**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2010**

6. DATE OF SURVEY **07/28/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **79** (L18)

13.Total Certified Beds **79** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Miller, HFE NE II 07/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/22/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/17/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN 24-5426

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245426

August 22, 2014

Mr. Michael Schultz, Administrator
Koda Living Community
2255 30th Street NW
Owatonna, Minnesota 55060

Dear Mr. Schultz:

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

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

Effective July 9, 2014 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 79 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 22, 2014

Mr. Michael Schultz, Administrator
Koda Living Community
2255 30th Street NW
Owatonna, Minnesota 55060

RE: Project Number S5426025; Complaint Numbers H5426017, H5426018, H5426019, & H5426020

Dear Mr. Schultz:

On July 18 and August 1, 2014, we informed you that the following enforcement remedies were being imposed:

• State Monitoring effective August 6, 2014. (42 CFR 488.422)

•Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 2, 2014. (42 CFR 488.417 (b))

• Civil Money penalty (42CFR 488.430 through 488.444).

This was based on the deficiencies cited by this Department for a standard survey completed on May 2, 2014, that included an investigation of complaint numbers H5426017, H5426018, H5426019, & H5426020, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on July 3, 2014. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 28, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 9, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 3, 2014, as of July 28, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 28, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of July 3, 2014. The CMS Region V Office concurred and authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 2, 2014, be rescinded. (42 CFR 488.417 (b))

We have also recommended the following to the Region V Office of CMS:

• Civil money penalties not be imposed. (42CFR 488.430 through 488.444)

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 2, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 2, 2014, is to be rescinded.

A copy of the Post Certification Revisit Form (CMS-2567B) from this visit is enclosed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245426	A. Building B. Wing	7/28/2014

Name of Facility	Street Address, City, State, Zip Code
KODA LIVING COMMUNITY	2255 30TH STREET NW OWATONNA, MN 55060

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0441** Reg. # **483.65** LSC	**07/28/2014**	ID Prefix **F0495** Reg. # **483.75(e)(4)** LSC	**07/28/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	08225/2014	03023	07/28/2014
CMS RO				

Followup to Survey Completed on: 5/2/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245426	A. Building B. Wing	7/28/2014

Name of Facility	Street Address, City, State, Zip Code
KODA LIVING COMMUNITY	2255 30TH STREET NW OWATONNA, MN 55060

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0495** Reg. # **483.75(e)(4)** LSC	**07/28/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	08/22/2014	03023	07/28/2014
CMS RO				

Followup to Survey Completed on: 5/2/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 342Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00644

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245426**

2.STATE VENDOR OR MEDICAID NO.
(L2) **046492200**

3. NAME AND ADDRESS OF FACILITY
(L3) **KODA LIVING COMMUNITY**
(L4) **2255 30TH STREET NW**
(L5) **OWATONNA, MN** (L6) **55060**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2010**

6. DATE OF SURVEY **07/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **79** (L18)

13.Total Certified Beds **79** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 07/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2252 0001 6356 5477

July 18, 2014

Mr. Michael Schultz, Administrator
Koda Living Community
2255 30th Street Nw
Owatonna, Minnesota 55060

RE: Project Number S5426025, Complaint Number H5426017, H5426018, H5426019 and H5426020

Dear Mr. Schultz:

On July 16, 2014, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 2, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on May 2, 2014, that included an investigation of complaint number H5426017, H5426018, H5426019, & H5426020, and lack of verification of substantial compliance with the health deficiencies at the time of our July 16, 2014 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 3, 2014, the Minnesota Department of Health and on June 22, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an standard survey, completed on May 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 9, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on May 2, 2014. The deficiencyies not corrected are as follows:

F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

In addition, at the time of this revisit, we identified the following deficiency(ies):

F0495 -- S/S: F -- 483.75(e)(4) -- Nurse Aide Work < 4 Mo - Training/competency

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute

no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective July 23, 2014. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 2, 2014. (42 CFR 488.417 (b))

However, as we notified you in our letter of May 20, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 2, 2014.

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 August 2, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 2, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 1, 2014

RE: Project Number S5426025, Complaint Numbers H5426017, H5426018, H5426019, H5426020

Dear Mr. Schultz:

PLEASE NOTE: This letter will replace the letter dated July 18, 2014. No further action is required. Your PoC has been accepted and the PCR has been completed.

On May 20, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 2, 2014 that included an investigation of complaint numbers H5426017, H5426018, H5426019, and H5426020. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 3, 2014, the Minnesota Department of Health and on June 22, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 9, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 2, 2014. The deficiency not corrected is as follows:

F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

In addition, at the time of this revisit, we identified the following deficiency:

F0495 -- S/S: F -- 483.75(e)(4) -- Nurse Aide Work < 4 Mo - Training/competency

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

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective August 6, 2014. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition and they have concurred with the following:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 2, 2014. (42 CFR 488.417 (b))

- Civil money penalty (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you regarding our recommendations and your appeal rights.

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

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

PLAN OF CORRECTION (PoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 August 2, 2014 (three months after the

identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 2, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 2, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245426	A. Building B. Wing	7/3/2014

Name of Facility	Street Address, City, State, Zip Code
KODA LIVING COMMUNITY	2255 30TH STREET NW OWATONNA, MN 55060

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **07/03/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/03/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/03/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **07/03/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **07/03/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/03/2014**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **07/03/2014**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **07/03/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/03/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	07/16/2014	19694	07/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/2/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245426	A. Building B. Wing **02 - KODA LIVING COMMUNITY**	6/22/2014

Name of Facility	Street Address, City, State, Zip Code
KODA LIVING COMMUNITY	2255 30TH STREET NW OWATONNA, MN 55060

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **06/11/2014**	ID Prefix	Correction Completed **06/11/2014**	ID Prefix	Correction Completed **06/11/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0017		LSC K0029		LSC K0054	
ID Prefix	Correction Completed **06/11/2014**	ID Prefix	Correction Completed **06/11/2014**	ID Prefix	Correction Completed **06/11/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0062		LSC K0144		LSC K0154	
ID Prefix	Correction Completed **06/11/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0155		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	07/16/2014	25822	06/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
4/30/2014	YES NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	R 07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KODA LIVING COMMUNITY	**2255 30TH STREET NW OWATONNA, MN 55060**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An on-site post certification revisit (PCR) was completed on July 1, 2, and 3, 2014 and the facility was found to have corrected all deficiencies issued except F441 which was reissued due to non-compliance at this tag and issued F495 due to findings during the PCR survey of non-compliance. The facility has not fully achieved full compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Also complaint/s H5426019, H5426018, H5426017 and H5426020 was completed. These four complaints were found to be corrected at tag/s F282, F309, F312, and F353 during this on-site PCR.	{F 000}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	{F 441}		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	R 07/03/2014

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{F 441}	Continued From page 1 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to minimize the risk of spreading infection during an open wound dressing change for 2 of 2 residents (R47 and R184) observed during wound dressing changes. Findings include: R47 was observed during wound care to right cheek on 7/1/14 at 10:15 a.m. with licensed practical nurse (LPN)-A. LPN-A was observed to	{F 441}	During Resident #14's wound dressing change on 4/30/2014, procedure was stopped due to breech in aseptic technique. New scissor was obtained, contaminated dressing was disposed of and new dressing was used. Dressing change continued with Resident #14's wound dressing change administered in accordance with physician's orders and facility policy using aseptic technique. As the facility recognizes the potential for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	R 07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KODA LIVING COMMUNITY	**2255 30TH STREET NW OWATONNA, MN 55060**

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{F 441}	Continued From page 2 wash hands, open wound care products, put on gloves. LPN-A then removed the soiled dressings from R47's face cheek, removed her gloves, washed her hands and put on new gloves. LPN-A was then observed to cleanse R47's wound with cleanser spray and to wipe the area with clean gauze using her right hand. LPN-A continued to wear soiled gloves and was observed to take a sterile Q-tip (cotton swab) and using her right gloved hand placed a packing into the open wound. LPN-A then dried the area with gauze and then removed her gloves, washed her hand, donned new gloves and applied the clean dressing. At 10:24 a.m. LPN-A verified she had not changed her gloves between cleansing the wound and packing the wound. R47 was admitted to the facility in 2012. The physician orders dated 6/2/14 recorded diagnoses list that included basal cell carcinoma skin-right cheek cancer. A physician order dated 2/4/14 directed dressing change right cheek cavity. The director of nursing was interview on 7/2/14 at 10:15 a.m. The DON stated the gloves should be changed between dirty and clean. R184 was observed on 7/1/14 at 10:30 a.m. during a wound dressing change provided by registered nurse (RN)-A. RN-A was observed to appropriately wash hands and change gloves during the wound dressing changes to R184's left foot and shoulder. However, a soiled paper measuring tap was used from one open ulcer to another during multiple ulcer treatments. R184 had a large open area with yellow slough	{F 441}	this alleged deficient practice to affect other residents, the DON re-educated all licensed nurses regarding cleaning and disinfecting of reusable equipment on 5/20/2014. Wound nurse, LPN was counseled and retrained regarding proper cleaning and disinfecting of reusable equipment and aseptic technique. Education included verbalized understanding. Wound nurse, LPN has been evaluated by the DON for competency of professional standards and has been found to meet those standards. A mandatory Nurse's meeting is scheduled for June 5th, 2014 at 1 :30pm to reinforce all POC re-education. To ensure continued compliance with proper aseptic technique and disinfection of equipment, the DON or designee will complete infection control round audits weekly X4 and monthly X3 and quarterly thereafter. Three of those audits will be completed on LPN Wound nurse during wound rounds. Audit results will be reported on the Quality Committee for further recom mendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	R 07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 3 (necrotic tissue in the process of separating from viable portions of the body) on top of left foot. After cleansing the area, RN-A used a paper tape measure to measure the size of the wounds. On the top of the foot the wound with yellow slough measured 8 cm x 4 cm by 1.5 cm deep. RN-A touched the wound with the soiled tape measure and placed the end of the tape measure into the wound to obtain the depth. R184 also had wounds on the top of the left foot just below the small toe, to the back edge of the large toe, and to the heel. RN-A measured each area using the same soiled paper tape measure which was put in the open wound on top left foot, but did not touch the wound or the surrounding skin area. All four areas on the left foot had clean treatments and dressing applied by RN-A before she moved on to R184 ' s back wounds. R184 had a large circular wound on her back that had defined edges and crater like inner surface. RN-A washed her hands and applied clean gloves before attending to this open area. RN-A using the same soiled paper tape measure which touched the open wound located on top of the foot by touching the tap to the open wound located on the resident's back. RN-A then used a sterile Q-tip (cotton swab) to measure the depth and tunneling of the wound, but allowed the soiled paper tape measure to touch the edges of the wound and surrounding skin when she measured the wound. R184 was admitted to the facility 4/17/14. The physician orders dated 6/2/14 listed diagnoses that included pressure ulcers. R184 ' s care plan identified a problem dated 5/14/14 of a stage 2 pressure ulcer from a fall a home and another	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	R 07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 441}	Continued From page 4 problem dated 4/29/14 of deep tissue injury to left foot and right shoulder wound as a result of fall at home. The interventions directed to record location, size, color, surrounding skin, presence/absence of drainage/pain/signs of healing every day and prn [as needed]. The director of nursing was interviewed on 7/2/14 at 10:15 a.m. She verified the measure tape used were made of paper and said that the measure tap should not be used if soiled during measurement on another wound. The director of nursing added R184 was being seen by the wound clinic and to the DON's knowledge did not have an infection at this time. The facility's policy entitled Dressings, Dry/Clean dated August 2011 was reviewed. The policy directed staff to cleanse the wound from least contaminated area to most contaminated area, dry the wound and apply the ordered dressing. The policy did not direct the changing of gloves between cleansing the wound and contaminated area and then applying a new dressing. During an interview on 7/2/14 at 10:55 a.m. the director of nursing stated the policy was incorrect and gloves should be changed when soiled to prevent the spread of infection.	{F 441}		
F 495 SS=F	483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide	F 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	R 07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KODA LIVING COMMUNITY	**2255 30TH STREET NW OWATONNA, MN 55060**

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F 495	Continued From page 5 training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure 10 of 10 employees (EE-A, EE-B, EE-C, EE-D, EE-E, EE-F, EE-G, EE-H,EE-I, EE-J), hired without a nursing assistant certification or the 16 hours of necessary training prior to providing direct resident care. This had the potential to affect 71 of 71 residents. Findings include: A nurse (N) that wishes to remain anonymous was interviewed on 7/2/14 at 10:29 a.m. N stated the facility was hiring people not certified, but letting them work on the floor without training. N stated that it "is unsafe" so can ' t do lifts and other things. N gave examples of when asked a care giver about peri-care the care giver did not know what this was about. The director of nursing (DON) and human resources (HR) director provided a list of 10 nursing assistants that had been hired in 2014. The 10 identified nursing assistants had been hired without nursing assistant certification. During an interview on 7/2/14 at 2:10 p.m. the director of nursing verified these nursing assistants had not completed a nursing assistant certification training program and that the facility had not provided a 16-hour nursing assistant training program. DON and HR could not verify	F 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	R 07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KODA LIVING COMMUNITY	**2255 30TH STREET NW OWATONNA, MN 55060**

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F 495	Continued From page 6	F 495		

that all the uncertified nursing assistants had been enrolled in a certification program. During an interview on 7/3/14 at 10:00 a.m. the director of nursing stated the mentoring of the hired nursing staff was provided under the direction of a certified nursing assistant for 1 to 2 weeks after general orientation had been completed. The DON again verified the uncertified nursing assistants were not provided the 16-hour training by a registered nurse and were not enrolled in a nursing assistant certification program when hired.

Employee (EE)-H was hired 1/28/14 and was terminated on 6/10/14 EE-H had not completed the nursing certification course during the 5 months of employment. EE-H had been enrolled in a nursing assistant training course, but had not completed the course prior to termination.

EE-I was hired 2/25/14 and was terminated on 6/23/14. EE-I had not completed the nursing certification course during the 4 months of employment. EE-I had completed the facility general orientation program on 2/25/14 and began working on the floor with a certified nursing assistant mentor on 2/27/14. EE-I had been enrolled in a nursing assistant certification training course, but had not completed the course prior to termination.

EE-J was hired 2/25/14 and terminated on 5/12/14. EE-J had completed the facility general orientation program on 2/25/14 and began working on the floor with a certified nursing assistant mentor on 2/26/14 EE-J had not completed the nursing assistant certification training course during the 3 months of employment. EE-J was not enrolled in a nursing

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F 495	Continued From page 7 assistant training program. EE-A was hired on 5/7/14 and was terminated prior to working with a mentor. EE-A had not completed a nursing assistant certification course prior to being hired and had not received a 16-hour facility based training program. EE-B was hired 5/7/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. During an interview on 7/2/14 at 2:00 p.m. DON stated she had attempted to contact EE-B related to need to complete the 16-hour program, but had not yet heard from her and that she would be terminated. EE-C was hired 5/22/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. EE-C was currently enrolled in nursing assistant certification training program at a technical college. EE-D was hired 6/5/14 and had not completed nursing assistant certification program or a 16-hour facility based training program. EE-D was provided mentoring by a certified nursing assistant 6/7/14. During an interview on 7/2/14 at 2:00 p.m. DON stated she had attempted to contact EE-D related to the need to complete the 16-hour program, but had not yet heard from her that that EE-D would be terminated. EE-E was hired 5/22/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. EE-E was provided a mentor following orientation. Information provided by HR on 7/2/14 at 3:00	F 495		

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p.m. indicated EE-E had not completed a State of Minnesota Background Study Clearance.

EE-F was hired on 3/20/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. Records provided by HR indicated EE-F had been provided only a partial mentoring program.

EE-G was hired on 4/22/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. EE-G was provided a mentor on 5/20/14 and was currently enrolled in a nursing assistant certification training program.

During an interview on 7/2/14 at 2:10 p.m. DON stated that between 5/2/14 and 6/25/14 fifteen nursing assistants had been hired, but that 5 of those hired were not certified and had not completed a facility based 16-hour training program. At 3:30 p.m. the director of nursing stated that in addition to the five hired since 5/2/14, the facility had hired an additional 5 untrained care givers and that two were still working at the facility.

Facility staffing schedules were reviewed for June 1, 2014 through June 30, 2014. EE-C, EE-F, EE-I, EE-G, EE-H, EE-E, EE-B, EE-D had been scheduled during the month of June 2014 and covered all 3 shifts on all 4 units.

During the interview on 7/2/14 at 2:10 p.m., the DON stated that these nursing assistants had work directly with resident/s care/s and after two weeks of mentoring with a certified nursing assistant, the uncertified care providers worked

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alone with the resident/s. DON stated that part of general orientation included abuse and infection control training. DON stated she was not aware the facility needed to provide a 16-hour training program for any uncertified nursing assistants hired. During an interview on 7/2/14 at 2:45 p.m. the director of nursing stated that was difficult to enroll students in a nursing assistant training program in this area of the state.

During an interview on 7/2/14 at 3:48 p.m. the quality coordinator verified that of the 10 uncertified care givers hired; only 5 had been enrolled in a nursing assistant certification class and that the others had not been enrolled in a class.

The administrator was interviewed on 7/3/14 at 8:45 a.m. He stated he had found a policy related to hiring practices dated 1/2014. The policy indicated a background study needed to be completed, but did not direct that a State of Minnesota background check be done or what procedures should be taken until the State background check was received so that nursing assistants could work with residents.

During an interview on 7/3/14 at 9 a.m. the director of nursing stated she understood the need for staff to have supervision if no background checks had been completed and knew that without a 16-hour training program, the non-certified staff could not provide direct resident care. The director of nursing stated the facility did not have a policy related to hiring non-certified care givers, 16-hour training of non-certified care givers, or need to enroll non-certified care givers in a nursing assistant certification training program. The director of

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F 495	Continued From page 10 nursing stated the mentoring program was provided by trained nursing assistant that had been trained prior to the director of nursing's date of hire (January 2014.)	F 495		

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{F 000}	INITIAL COMMENTS An on-site post certification revisit (PCR) was completed on July 1, 2, and 3, 2014 and the facility was found to have corrected all deficiencies issued except F441 which was reissued due to non-compliance at this tag and issued F495 due to findings during the PCR survey of non-compliance. The facility has not fully achieved full compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Also complaint/s H5426019, H5426018, H5426017 and H5426020 was completed. These four complaints were found to be corrected at tag/s F282, F309, F312, and F353 during this on-site PCR.	{F 000}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	{F 441}		7/9/14

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

Electronically Signed | 07/18/2014

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 441}	Continued From page 1 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to minimize the risk of spreading infection during an open wound dressing change for 2 of 2 residents (R47 and R184) observed during wound dressing changes. Findings include: R47 was observed during wound care to right cheek on 7/1/14 at 10:15 a.m. with licensed practical nurse (LPN)-A. LPN-A was observed to	{F 441}	Re-education completed immediately with LPN-A and RN-A on 7/2/2014.3 Clean Dressing Policy/Procedure was revised immediately on 7/2/2014 and distributed to all licensed nursing. Residents R47 and R184 suffered no known adverse outcomes. Director of Nursing and a facility LPN are Wound Care Certified. LPN WCC follows the wounds weekly during rounds. DON	

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{F 441}	Continued From page 2 wash hands, open wound care products, put on gloves. LPN-A then removed the soiled dressings from R47's face cheek, removed her gloves, washed her hands and put on new gloves. LPN-A was then observed to cleanse R47's wound with cleanser spray and to wipe the area with clean gauze using her right hand. LPN-A continued to wear soiled gloves and was observed to take a sterile Q-tip (cotton swab) and using her right gloved hand placed a packing into the open wound. LPN-A then dried the area with gauze and then removed her gloves, washed her hand, donned new gloves and applied the clean dressing. At 10:24 a.m. LPN-A verified she had not changed her gloves between cleansing the wound and packing the wound. R47 was admitted to the facility in 2012. The physician orders dated 6/2/14 recorded diagnoses list that included basal cell carcinoma skin-right cheek cancer. A physician order dated 2/4/14 directed dressing change right cheek cavity. The director of nursing was interview on 7/2/14 at 10:15 a.m. The DON stated the gloves should be changed between dirty and clean. R184 was observed on 7/1/14 at 10:30 a.m. during a wound dressing change provided by registered nurse (RN)-A. RN-A was observed to appropriately wash hands and change gloves during the wound dressing changes to R184's left foot and shoulder. However, a soiled paper measuring tap was used from one open ulcer to another during multiple ulcer treatments. R184 had a large open area with yellow slough	{F 441}	WCC assists in assessing wounds as needed. DON WCC covers LPN WCC during her absence. As the facility recognizes this alleged deficient practice has the potential to affect other residents, the Director of Nursing and Wound Care Nurse have evaluated, re-educated and/or retrained individual nurses one-on-one during resident dressing changes, as needed. All nurses will be re-educated on 7/22/2014 at a Mandatory Nurse's meeting regarding revised procedure for Clean Dressing Change and proper dressing change technique to prevent contamination of wounds. LPN-A and RN-A were counseled and retrained regarding proper aseptic technique, cross contamination of wounds and changing of gloves during dressing change procedures. Education included return demonstrations and verbalized understanding. To Ensure continued compliance with proper aseptic technique during dressing changes, the Director of Nursing or designee will complete 8 Infection Control Audits weekly X4 and 8 monthly X3 and 8 quarterly, thereafter. Auditing of LPN-A and RN-A will be included once during each of the weekly, monthly and quarterly audits. Audit results will be reported to the Quality Assurance Committee for review or further recommendations as needed.	

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{F 441}	Continued From page 3 (necrotic tissue in the process of separating from viable portions of the body) on top of left foot. After cleansing the area, RN-A used a paper tape measure to measure the size of the wounds. On the top of the foot the wound with yellow slough measured 8 cm x 4 cm by 1.5 cm deep. RN-A touched the wound with the soiled tape measure and placed the end of the tape measure into the wound to obtain the depth. R184 also had wounds on the top of the left foot just below the small toe, to the back edge of the large toe, and to the heel. RN-A measured each area using the same soiled paper tape measure which was put in the open wound on top left foot, but did not touch the wound or the surrounding skin area. All four areas on the left foot had clean treatments and dressing applied by RN-A before she moved on to R184 ' s back wounds. R184 had a large circular wound on her back that had defined edges and crater like inner surface. RN-A washed her hands and applied clean gloves before attending to this open area. RN-A using the same soiled paper tape measure which touched the open wound located on top of the foot by touching the tap to the open wound located on the resident's back. RN-A then used a sterile Q-tip (cotton swab) to measure the depth and tunneling of the wound, but allowed the soiled paper tape measure to touch the edges of the wound and surrounding skin when she measured the wound. R184 was admitted to the facility 4/17/14. The physician orders dated 6/2/14 listed diagnoses that included pressure ulcers. R184 ' s care plan identified a problem dated 5/14/14 of a stage 2 pressure ulcer from a fall a home and another	{F 441}		

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{F 441}	Continued From page 4 problem dated 4/29/14 of deep tissue injury to left foot and right shoulder wound as a result of fall at home. The interventions directed to record location, size, color, surrounding skin, presence/absence of drainage/pain/signs of healing every day and prn [as needed]. The director of nursing was interviewed on 7/2/14 at 10:15 a.m. She verified the measure tape used were made of paper and said that the measure tap should not be used if soiled during measurement on another wound. The director of nursing added R184 was being seen by the wound clinic and to the DON's knowledge did not have an infection at this time. The facility's policy entitled Dressings, Dry/Clean dated August 2011 was reviewed. The policy directed staff to cleanse the wound from least contaminated area to most contaminated area, dry the wound and apply the ordered dressing. The policy did not direct the changing of gloves between cleansing the wound and contaminated area and then applying a new dressing. During an interview on 7/2/14 at 10:55 a.m. the director of nursing stated the policy was incorrect and gloves should be changed when soiled to prevent the spread of infection.	{F 441}		
F 495 SS=F	483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide	F 495		7/3/14

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F 495	Continued From page 5 training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure 10 of 10 employees (EE-A, EE-B, EE-C, EE-D, EE-E, EE-F, EE-G, EE-H,EE-I, EE-J), hired without a nursing assistant certification or the 16 hours of necessary training prior to providing direct resident care. This had the potential to affect 71 of 71 residents. Findings include: A nurse (N) that wishes to remain anonymous was interviewed on 7/2/14 at 10:29 a.m. N stated the facility was hiring people not certified, but letting them work on the floor without training. N stated that it "is unsafe" so can ' t do lifts and other things. N gave examples of when asked a care giver about peri-care the care giver did not know what this was about. The director of nursing (DON) and human resources (HR) director provided a list of 10 nursing assistants that had been hired in 2014. The 10 identified nursing assistants had been hired without nursing assistant certification. During an interview on 7/2/14 at 2:10 p.m. the director of nursing verified these nursing assistants had not completed a nursing assistant certification training program and that the facility had not provided a 16-hour nursing assistant training program. DON and HR could not verify	F 495	Employees EE-H, EE-I, EE-J and EE-A were terminated from employment prior to date of survey. Employees EE-B, EE-C, EE-D, EE-E, EE-F and EE-G were removed from facilities working schedule immediately. employees EE-C, EE-D, EE-E and EE-F were brought into the facility on 7/02/2014 and the 16 hours of training in the subjects listed under 483.75(e) (2-4) were provided by facility RN with competency skills evaluated and deemed proficient by RN. Due to the inability to reach employees EE-B and EE-D to report to facility for training, both employees' employment was terminated on 7/03/2014. Employees EE-E and EE-F were immediately enrolled into a State approved CNA training program through the Riverland Community College. Employee EE-E was removed from direct resident care duties until Minnesota Background Study was cleared on 7/07/2014. Training and correction was completed at 1500 on 7/03/2014. Policy for hiring new employees will be revised to include non-certified nursing assistance and the requirements necessary for them to provide direct care. At this time we will not be hiring non-certified nursing assistants. If hiring	

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F 495	Continued From page 6 that all the uncertified nursing assistants had been enrolled in a certification program. During an interview on 7/3/14 at 10:00 a.m. the director of nursing stated the mentoring of the hired nursing staff was provided under the direction of a certified nursing assistant for 1 to 2 weeks after general orientation had been completed. The DON again verified the uncertified nursing assistants were not provided the 16-hour training by a registered nurse and were not enrolled in a nursing assistant certification program when hired. Employee (EE)-H was hired 1/28/14 and was terminated on 6/10/14 EE-H had not completed the nursing certification course during the 5 months of employment. EE-H had been enrolled in a nursing assistant training course, but had not completed the course prior to termination. EE-I was hired 2/25/14 and was terminated on 6/23/14. EE-I had not completed the nursing certification course during the 4 months of employment. EE-I had completed the facility general orientation program on 2/25/14 and began working on the floor with a certified nursing assistant mentor on 2/27/14. EE-I had been enrolled in a nursing assistant certification training course, but had not completed the course prior to termination. EE-J was hired 2/25/14 and terminated on 5/12/14. EE-J had completed the facility general orientation program on 2/25/14 and began working on the floor with a certified nursing assistant mentor on 2/26/14 EE-J had not completed the nursing assistant certification training course during the 3 months of employment. EE-J was not enrolled in a nursing	F 495	needs change all non-certified nursing assistants will: a. Meet all pre-hire requirements prior to giving direct care b. Attend 8 hour General Orientation Session. c. will be enrolled into a State approved Nursing Assistant Certification Program at time of hire. d. Attend a RN instructed 16 hour training course as meeting all areas as listed in 483.75 (e) (2-4) e. Skills evaluation check-offs will be completed by an RN. f. Orientate with CNA-mentor for 7 days or as needed prior to working independently. All employees will be scheduled to give direct resident care independently only after Minnesota Background study is passed. Prior to receiving a cleared background study all new hires will be under the supervision of a certified or licensed employee who has a cleared CBC. Staff development Director will be responsible to assure non-certified employees are trained according to MDH requirements. Human Resource Manager will be responsible to ensure that all Minnesota Background studies are passed and clear prior to any resident direct contact. a. Audits will be completed if non-certified employees are hired to assure compliance with training and competence of skills. b. Audits will be conducted to assure	

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F 495	Continued From page 7 assistant training program. EE-A was hired on 5/7/14 and was terminated prior to working with a mentor. EE-A had not completed a nursing assistant certification course prior to being hired and had not received a 16-hour facility based training program. EE-B was hired 5/7/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. During an interview on 7/2/14 at 2:00 p.m. DON stated she had attempted to contact EE-B related to need to complete the 16-hour program, but had not yet heard from her and that she would be terminated. EE-C was hired 5/22/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. EE-C was currently enrolled in nursing assistant certification training program at a technical college. EE-D was hired 6/5/14 and had not completed nursing assistant certification program or a 16-hour facility based training program. EE-D was provided mentoring by a certified nursing assistant 6/7/14. During an interview on 7/2/14 at 2:00 p.m. DON stated she had attempted to contact EE-D related to the need to complete the 16-hour program, but had not yet heard from her that that EE-D would be terminated. EE-E was hired 5/22/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. EE-E was provided a mentor following orientation. Information provided by HR on 7/2/14 at 3:00	F 495	Background studies are being completed prior to giving direct resident care independently. Director of Nursing or designee will monitor audits for compliance. Audits will be reviewed at Quality Assurance Committee Meetings. completion date: July 3, 2014 with audits ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	R 07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KODA LIVING COMMUNITY	**2255 30TH STREET NW OWATONNA, MN 55060**

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F 495	Continued From page 8	F 495		

p.m. indicated EE-E had not completed a State of Minnesota Background Study Clearance.

EE-F was hired on 3/20/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. Records provided by HR indicated EE-F had been provided only a partial mentoring program.

EE-G was hired on 4/22/14 and had not completed a nursing assistant certification training program or a 16-hour facility based training program. EE-G was provided a mentor on 5/20/14 and was currently enrolled in a nursing assistant certification training program.

During an interview on 7/2/14 at 2:10 p.m. DON stated that between 5/2/14 and 6/25/14 fifteen nursing assistants had been hired, but that 5 of those hired were not certified and had not completed a facility based 16-hour training program. At 3:30 p.m. the director of nursing stated that in addition to the five hired since 5/2/14, the facility had hired an additional 5 untrained care givers and that two were still working at the facility.

Facility staffing schedules were reviewed for June 1, 2014 through June 30, 2014. EE-C, EE-F, EE-I, EE-G, EE-H, EE-E, EE-B, EE-D had been scheduled during the month of June 2014 and covered all 3 shifts on all 4 units.

During the interview on 7/2/14 at 2:10 p.m., the DON stated that these nursing assistants had work directly with resident/s care/s and after two weeks of mentoring with a certified nursing assistant, the uncertified care providers worked

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F 495	Continued From page 9	F 495		

alone with the resident/s. DON stated that part of general orientation included abuse and infection control training. DON stated she was not aware the facility needed to provide a 16-hour training program for any uncertified nursing assistants hired. During an interview on 7/2/14 at 2:45 p.m. the director of nursing stated that was difficult to enroll students in a nursing assistant training program in this area of the state.

During an interview on 7/2/14 at 3:48 p.m. the quality coordinator verified that of the 10 uncertified care givers hired; only 5 had been enrolled in a nursing assistant certification class and that the others had not been enrolled in a class.

The administrator was interviewed on 7/3/14 at 8:45 a.m. He stated he had found a policy related to hiring practices dated 1/2014. The policy indicated a background study needed to be completed, but did not direct that a State of Minnesota background check be done or what procedures should be taken until the State background check was received so that nursing assistants could work with residents.

During an interview on 7/3/14 at 9 a.m. the director of nursing stated she understood the need for staff to have supervision if no background checks had been completed and knew that without a 16-hour training program, the non-certified staff could not provide direct resident care. The director of nursing stated the facility did not have a policy related to hiring non-certified care givers, 16-hour training of non-certified care givers, or need to enroll non-certified care givers in a nursing assistant certification training program. The director of

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F 495	Continued From page 10 nursing stated the mentoring program was provided by trained nursing assistant that had been trained prior to the director of nursing's date of hire (January 2014.)	F 495		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 342Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00644

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245426**

2.STATE VENDOR OR MEDICAID NO.
(L2) **046492200**

3. NAME AND ADDRESS OF FACILITY
(L3) **KODA LIVING COMMUNITY**
(L4) **2255 30TH STREET NW**
(L5) **OWATONNA, MN** (L6) **55060**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2010**

6. DATE OF SURVEY **05/02/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **79** (L18)

13.Total Certified Beds **79** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 05/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 24-5426

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), In addition at the time of the survey four complaints were investigated and found to be substantiated. Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 16, 2014

Mr. Michael Schultz, Administrator
Koda Living Community
2255 30th Street Nw
Owatonna, Minnesota 55060

RE: Project Numbers S5426025, H5426017, H5426018, H5426019, and H5426020.

Dear Ms. Schneider:

On May 2, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the May 2, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5426017, H5426018, H5426019, and H5426020.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 11, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 11, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 2, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 2, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KODA LIVING COMMUNITY	2255 30TH STREET NW OWATONNA, MN 55060

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigations were also completed at the time of the standard survey. An investigation of complaint H5426019, H5426018, H5426017 and H5426020 was completed. The four complaints were substantiated with deficiencies issued at F282, F309, F312, and F353.	F 000		
F 244 SS=C	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 244	Preparation, submission and	6/11/14

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

Electronically Signed | 05/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 244	Continued From page 1 facility failed to act upon resident grievances related to the temperature of the food served. This had the potential to affect all 69 residents who received their meals from the facility's kitchen. Findings include: The resident council meeting minutes were reviewed and documentation included: (1) 2/17/14- Food is not as hot as it could be. Short term unit. Follow-up indicated at the monthly staff meeting to include cold foods. We do have plate warmers and the food is temped when it arrives in the neighborhood kitchens to make sure it is at the proper temperature. (2) 3/17/14- Food is cold sometimes and the majority of residents would like to see more of a variety, was reported on the Oak unit. Cold food at times was reported on the Dawn Unit. There was no documentation of follow up related to the concerns of cold food for resident council for the month of March. (3) 4/28/14- long and short term units. Two residents reported they would like to see more of a variety on the menu. Four residents voiced concern the food is cold sometimes. During an interview on 4/30/14 at 6:24 p.m., the social wellness director (SWD) verified for February, March and April 2014 there were concerns at the resident council meetings of food being too cold. The SWD verified there was no documented follow-up for the March resident council meetings related to cold food. The SWD also verified the April resident council meetings were held on 4/28/14 and there had been no follow-up to the resident concerns at this time related to cold food. The SWD stated residents	F 244	implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. No individual residents were noted on the written F tag. All new residents are provided with written material on admission explaining the facility "Grievance/Concern Policy". The facility has five binders around the facility which provides residents and families with information and forms if they would like to submit a concern in writing. In the June statements, written information will be included informing the residents' responsible parties of the facility Grievance/Concern Policy. All employees are provided with a copy of the facility "Grievance/Concern Policy" at time of hire. Written information and education material will be made available for all current employees on the current policy as a refresher. The Social Wellness Director who is the facilitator of the Resident council will provide the Culinary Director with a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 244	Continued From page 2 have voiced concerns of cold food at the tables in the dining rooms as well when they receive room trays in their rooms. Verified this has been on ongoing problem in both the long and short term halls and stated the "food is cold sometimes." Review of the Resident Council policy dated February 2013 read ... " the facility demonstrates follow-through on written requests/concerns voiced by the Resident Council. " During an interview on 5/2/14 at 11:21 a.m., activities staff member (ASM)-A verified the facility did not follow their policy to follow -up on concerns related to cold food for the resident council meeting the month of March 2014.	F 244	completed "Resident Council Concern Form" after any concerns are voiced from Resident Council in regards to culinary concerns. The Culinary Director will review the concerns and write a response and write a plan of correction if needed and provide this to the Social Wellness Director to bring back to the next Resident Council meeting. To encourage an open discussion in regards to the culinary services at Koda, the Culinary Director and the Director of Guest Services scheduled a family Culinary meeting on May 21, 2014 and no families attended. This will be offered again on June 19th, 2014 to encourage family involvement in planning our culinary services. Our Resident Council facilitator will review the facility Grievance Policy and Resident Council policy will all participants at the next Resident Council meeting held in June. The resident's will be educated on the facility policy and how their concerns will be handled when they are brought forth. When concerns are brought forth through the Resident Council, the facilitator will follow the process for addressing these concerns in a timely manner. Individual concerns will be noted on the "Facility Customer Feedback Form" and given to the department manager that the concern pertains to. If there is an overall group concern, then this will be noted on the "Resident Council Concern Form" and	

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F 244	Continued From page 3	F 244	given to the department manager for review and follow-up. The facilitator will provide a response back to the Resident Council participants during the next scheduled meeting on any concerns that are brought up by this group during the previous meeting. During the next three months, as concerns are voiced by the Resident Council, the Resident Council facilitator will share the concerns and the responses/corrections of these concerns brought up by the group with the Director of Guest Services for review to ensure compliance with facility policy of handling resident concerns. The applicable facility policies were reviewed for accuracy and appropriateness and no updates were needed. Date of completion will be June 11, 2014.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide grooming services in accordance with the plan of care for 2	F 282	Resident #81 and Resident #88 were provided with nail care on 5/1/2014. Care plans and care sheets of Residents #14,	6/11/14

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F 282	Continued From page 4 of 4 residents (R81, R88) in the sample reviewed for personal cares; failed to provide toileting services in accordance with the plan of care for 2 of 4 residents (R81, R14) reviewed for personal cares; and failed to provide care in accordance with the plan of care for 1 of 1 residents (R88) reviewed with diabetic ulcers. Findings include: R81 was observed at 7:45 p.m. on 4/30/14 and was noted to have dark polished finger nails, but also to have brown debris under the nails. Family (F)-B and F-C were interviewed on 4/30/14 at 7:00 p.m. and they said they had noted R81 had lacked hand washing before meals and had dirty fingernails. F-B and F-C added the fingernails were not cleaned with baths. F-B stated the last time R81 had been hospitalized; F-B was told R81 had feces found under the finger nails. R81 ' s physician orders dated 4/1/14 noted R81 had diagnoses that included: chronic airway obstruction, mild cognitive impairment, depressive disorder, generalized pain. The annual Minimum Data Set (MDS) dated 2/18/14 was reviewed. The BIMS (brief interview of mental status) was 10 out of 15 or moderate cognitive impairment. The MDS also indicated R81 required extensive assistance of two for bathing. R81 ' s care plan dated 5/10/12 directed R81 needed assistance with bathing/personal hygiene and that staff were to provide full assistance with nail care during bath/shower. Review of the point of care (computer program) documentation indicated weekly baths, but did not document provision of nail care. R88 was observed on 4/29/14 at 10:54 a.m. and	F 282	#81, and #88 were reviewed and revised as appropriate. Nurses and CNAs in the Dawn Neighborhood were re-educated on following the care plans for ADL assistance, toileting assistance and ulcer prevention. Also counseled on responding timely to resident's verbal calls for assistance and/or call lights. All Residents, facility wide, were observed to ensure nail care was provided as appropriate. Nail care was completed on all resident nails that needed trimming and/or cleaning. All resident care plans in the EHR/POC systems were revised as needed, to ensure the inclusion of nail care per qualified persons. All care plans will be reviewed to determine if all problems and approaches are defined. Nursing staff caring for Resident #81 and Resident #88 were reminded of care planned interventions regarding nail care on 5/1/2014. The facility utilizes Care Sheets for the CNAs that details information from the care plan which includes nail care, toileting and special interventions for ulcer prevention that can be completed by CNAs. Nurses were educated on their responsibility to ensure the CNAs complete these tasks. All nursing staff received education regarding policy and procedure on nail care and following all care plan approaches on 5/19/2014. A mandatory Nurse's meeting is scheduled for June 5th, 2014 at 1:30pm to reinforce all POC re-education.	

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F 282	Continued From page 5 noted to have long un-trimmed fingernails. The medication administration record dated 3/25/14 indicated R88 had diagnoses that included: diabetes, generalized pain, weakness. The quarterly MDS dated 3/17/14 was reviewed. R88 had a BIMS score of 15 or no cognitive impairment, and required extensive assistance of one for personal hygiene and total dependence on staff for bathing. The care plan dated 8/28/12 had a problem of bathing/personal hygiene that directed provide full staff assistance for nail care to hands and feet weekly with bath/shower. The facility policy entitled Shower/Tub Bath dated October 2010 read, "6. Perform nail care ..." The facility policy entitled Care of Fingernails/Toenails dated October 2010 and signed by the director of nursing 4/16/14 read, "1. Nail care will be completed on bath/shower days, but also includes daily cleaning and regular trimming." The policy also indicated the date and time nail care was provided was to be documented. The director of nursing (DON) was interviewed on 5/1/14 at 11:10 a.m. and stated her expectations were that fingernails were to be cleaned during showers and any time staff noticed the fingernails to be dirty. Washing of face and hands was to be done before and after meals. DON stated she did not know why fingernail cleaning was not being down. On 5/2/14 at 10:25 a.m. DON stated she would expect staff to follow the care plan. During an interview on 5/2/14 at 11:10 a.m. nursing assistant (NA)-C stated resident fingernails were to be cleaned after baths using a wooden stick to clean them.	F 282	Audits for resident #81 and Resident #88 and facility wide random audits will be conducted to ensure care plans are followed regarding nail care weekly X4, and monthly X3 and quarterly thereafter. Audits for Resident #14, Resident #81 and facility wide random audits will be conducted to ensure care plans are followed regarding toileting plans weekly X4, and monthly X3 and quarterly thereafter. Audits for Resident #88 will be conducted to ensure care plans are followed regarding application of heel protectors weekly X4, monthly X3 and quarterly thereafter. Audit results will be reported to the Quality Committee for further recommendations. Completion date: June 11th, 2014. Audits will be ongoing.	

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F 282	Continued From page 6 TOILETING SERVICES WERE NOT PROVIDED AS CARE PLANNED: R81 was observed on 4/29/14 at 5:00 p.m. and was interviewed. At that time the resident complained that she was not provided toileting assistance as needed to prevent being incontinent at which time she stated, Peed in pants because I did not make it to the bathroom in time. Family (F)-B and F-C were interviewed on 4/30/14 at 7:00 p.m. and they both said they came in to visit R81 every evening to help their mother. They would help get R81 to and from the toilet and help R81 get ready for bed because they felt staff was not providing these cares timely. The physician orders dated 4/1/14 noted R81 had diagnoses that included: recurrent dysuria (painful urination), cystitis (bladder infection), mild cognitive impairment, generalized pain. The annual Minimum Data Set (MDS) dated 2/18/14 was reviewed. The BIMS (brief interview of mental status) was 10 out of 15 or moderate cognitive impairment. The MDS also indicated R81 required extensive assistance of two staff for toileting. The care plan dated 3/15/13 indicated R81 needed toileting assistance every two hours and was at times incontinent of bladder. During an interview on 5/2/14 at 10:25 a.m. the DON stated she would expect staff to follow the care plan. R14 was observed on 4/28/14 at 6:15 a.m. crying and said, "Take me to bathroom please!" R14 was observed to be restless while in bed. No staff	F 282		

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entered room to help her until 6:23 a.m. then staff wheeled her to the shower room. On 4/30/14 at 3:10 p.m. R14 was observed lying in bed and again was crying "Help me!" The room had a foul odor of stool. At 3:15 R14 continued to call out "Help me!" At 3:35 p.m. (a period 25 minutes of crying before any staff checked resident ' s crying) nursing assistant (NA)-A entered room and prepared to transfer R14 to chair, but did not check R14 for incontinence or offer toileting services. At 3:50 p.m. R14's visitor asked staff to please take R14 to the bathroom and at 3:58 p.m. the registered nurse (RN)-E coordinator told a nursing assistant that R14 needed to use the bathroom. At 4:05 p.m. (a total of 55 minutes from the time R14 started crying for help staff checked incontinence product) NA-A and NA-B were observed to check R14 ' s incontinence brief at which time they changed a soiled incontinence brief.

The physician orders dated 4/2/13 had diagnoses that included rheumatoid arthritis, hip bursitis, chronic pain, depression. The annual MDS dated 1/9/14 indicated R14 had a BIMS of 15 or no cognitive impairment, required extensive assistance with toileting, was occasionally incontinent of urine. The care plan dated 4/3/14 had a goal of " resident will continue to assist with toileting. " The care plan directed offer toileting every 2 to 3 hours; provide extensive assist of 1 to transfer/clothing management/hygiene for toileting.

On 5/2/14 at 10:25 a.m. the director of nursing stated she would expect staff to follow R14 ' s care plan.
R88 was observed on 4/30/14, at 2:32 p.m., sitting in a wheel chair in his room watching

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television. R88 was wearing socks, and his legs were flexed with both feet on the floor. Two pairs of heel protectors were lying in a wheelchair. R88 remained sitting in his wheelchair with his feet on the floor until 6:20 p.m. At that time his right foot was up on the foot pedal. R88 stated he had turned the foot pedal and placed his foot on the foot pedal. Also during observation period R88 did not have the arterial assist pump devices on until he was put to bed and was not repositioned from wheelchair. R88 was observed from 2:32 p.m., until 7:29 p.m.

Care plan: Problem start date 2/20/14 read, "Diabetic foot ulcer with component of pressure left foot. Interventions: Follow up with wound clinic as ordered. Apply Air Assist pumps 1 hour 3x/day while sitting up in chair. remove shoes, apply boot until heeled. Dressing per wound nurse, change daily. Wound nurse to follow until healed. Monitor pain and offer pain medications as needed. Nursing to document s/s [signs and symptoms] of infection daily until healed."

R88's physician orders dated 4/21/14, included, "Arterial Assist Pump-use pump bilateral lower legs for 1 hour 3 x [times] daily while resident is sitting to augment arterial blood flow, reduce edema and promote healing.

During an interview at 10:25 a.m., on 5/1/14, the Director of Nursing (DON) confirmed that R88's heel protectors and assist pump device should be on when up in the chair.

Policy: Pressure Ulcers/Skin Care Policy. Reviewed policy from 2/16/14, no areas noted that facility are not following.

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan that addressed dialysis check of shunt and what to do in case of bleeding from the shunt for 1 of 1 resident (R137) who received dialysis services and failed to provide pressure relieving devices as directed in the care plan for 1 of 2 residents (R88) with an open vascular (diabetic) wound. Findings include: R137 was a dialysis patient receiving dialysis services three days a week from Mayo Clinic Dialysis Unit. R137 ' s family (F)-A said during an interview on 5/1/14 at 12:30 p.m. that R137 had received dialysis therapy for 5 years. The physician orders signed 4/16/14 indicated R137 was admitted to the facility 2/12/14 and had diagnoses of end stage renal disease (ESRD), chronic pain, history of pneumonia, leukocytosis, fluid overload, ischemic heart disease, congestive heart failure (CHF), chronic airways obstruction (COPD.)	F 309	Resident #137 care plan and treatment record were reviewed and updated with appropriate dialysis access site interventions for monitoring site. Resident #137 has discharged to home with Hospice services. Care plan and care sheet of Resident #88 were reviewed and found appropriate. Nurses and CNAs in the Dawn Neighborhood were re-educated on following the care plans for ordered treatments and ulcer prevention interventions. One other resident was receiving dialysis services. MAR, TAR and care plan were reviewed to ensure daily monitoring of dialysis access site was completed and documented as ordered. Documentation was complete. Resident no longer resides in the facility. No other residents within the facility were receiving dialysis services at this time. All residents with documented skin concerns facility wide were observed to ensure treatment orders and care plan	6/11/14

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F 309	Continued From page 10 R137 was observed on 5/1/14 at 12:30 p.m. at the dinner table in the dining room. F-A and F-B, F-C and F-D were present. During observations R137's breathing was noted to be labored and when asked if he had pain he pointed to his chest. F-A stated R137 had been having trouble breathing for the past 3 days and was at dialysis yesterday. The Mayo Clinic Dialysis Service Memorandum of Understanding dated March 2014 was reviewed. The MCDS read, "check dialysis access arm (AV [arterial/vascular] fistula or AV graft) for pulse or bruit twice a day. " R137 ' s comprehensive plan of care printed and provided 5/1/14 did not identify a problem related to dialysis, identification of type of access, location of access, or monitoring of dialysis access. The medication administration record (MAR) and treatment record were reviewed. On the MAR the following information was added on 4/28/14 after the facility was queried about this information "Monitor dialysis site daily each shift." The site was monitored/checked twice on the 29, once on the 30 and not on May 1 nor 2, 2014 according to the documentation. On 5/2/14 at 10:30 a.m. the director of nursing stated she had identified last month that the VA access was not being monitored. At that time the DON stated she had placed the monitoring on the treatment administration record for three times a day and educated staff this week. She verified the monitoring of the access was not being signed off on the MAR. R88 was randomly observed from 2:32 p.m. to 7:45 p.m. (a total of 5 hours and 13 minutes) without heel protectors or arterial assist pump	F 309	approaches are being provided and documented on as ordered. A. All licensed nursing staff were educated on 5/20/2014 regarding the facilities policy and procedure for monitoring dialysis access sites and providing treatments and documenting accordingly as ordered. Re-educated on developing care plans for dialysis residents. B. All licensed nursing staff were educated on 5/20/2014 regarding Care Plan and CNA Care Sheet updating and following all care plan approaches as written. The facility utilizes Care Sheets for the CNAs that details information from the care plans. Nurses were educated on their responsibility to ensure the CNAs complete these tasks if appropriate. C. A mandatory Nurse's meeting is scheduled for June 5th, 2014 at 1:30 pm to reinforce all POC re-education. At this time, there are no residents in the facility receiving dialysis services. Random audits will be conducted by the DON or designee for any resident on dialysis, to ensure treatment, treatment documentation and care plans are followed weekly X4, monthly X3 and quarterly thereafter. Audits for Resident #88 will be conducted to ensure care plans are followed regarding application of heel protectors weekly X4, monthly X3 and quarterly thereafter. Audit results will be reported to the Quality Committee for	

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F 309	Continued From page 11 devices in place while seated in an upright position in the wheel chair as per R88's care plan. R88 was observed on 4/30/14, at 2:32 p.m., sitting in a wheel chair in his room watching television. R88 was wearing socks, and his legs were flexed at the knee with both feet on the floor. Two pairs of heel protectors were observed lying in a nearby chair. At 5:25 p.m. kitchen staff was observed to deliver R88's supper tray. R88 remained sitting in his wheelchair with his feet on the floor until 6:20 p.m. At that time his right foot was up on the foot pedal. R88 stated he had turned the foot pedal and placed his foot on the foot pedal by himself. On 4/30/14 at 7:45 p.m., R88 was transferred to the toilet and then to bed by nursing assistant (NA)-B using a stand-up lift. NA-B removed R88's socks and an ace wrap and left a white stocking on over the resident's left heel dressing. NA-B then put socks back on both feet per R88's request and applied blue heel protectors to both feet. On 5/2/14 at 7:20 a.m., NA-H was getting R88 ready for his shower. When questioned by surveyor, NA-H stated LPN-A had instructed her to scrub the right heel. When NA-H returned from the shower she stated she had scrubbed R88's right foot with a wash cloth and that the right heel wound was healed over. The surveyor was able to observe the right heel, and noted the heel to be healed. On 5/2/14 at 8:10 a.m., Registered Nurse (RN)-E re-measured R88's right heel wound. The wound had been measured on 5/1/14 by LPN-C. RN-E stated that the wound measure 6.5 x 4 and it	F 309	further recommendations. Completion date: June 11th, 2014. Audits will be ongoing.	

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F 309	Continued From page 12 increased in size. At 9:50 a.m. RN-E confirmed that R88's heel protectors should be on both feet when up out of bed. R88's quarterly Minimum Data Set (MDS) dated 3/17/14 included: no cognitive impairment, required extensive assistance with bed mobility and transfers. R88 was at risk for pressure ulcers, did not have a pressure ulcer, but had a diabetic foot ulcer which was located on the right heel. R88's Physician Order Sheet dated 4/21/14, included diagnoses of: "Ulcer other part of foot-diabetic," diabetes mellitus type II, renal (kidney) failure, malnutrition, amebic skin-Left heel, neuropathy (decrease sensation of the extremities). Push fluids. American diabetic association diet. Also taking aspirin, Prostate for malnutrition (protein/amino acid supplement), ferrous sulfate (iron supplement.) R88's physician orders dated 4/21/14, included, "Arterial Assist Pump-use pump bilateral lower legs for 1 hour 3 x [times] daily while resident is sitting to augment arterial blood flow, reduce edema and promote healing. Ulcer treatment left lateral 5th metatarsal [toe]: 1. Gently cleanse ulcer base with normal saline and gauze. 2. Apply Iodosorb/Curafil [absorb and dressing] mixture to ulcer base. 3. Cover with dry dressing and secure with roll gauze. Once a day; 6 a.m. - 2 p.m. Ulcer care left heel: 1. Gently cleanse ulcer base with normal saline and gauze. 2. Apply Iodosorb [iodine infused dressing] only to ulcer base. 3. Cover with dry gauze and secure with roll gauze. 4. Change dressing daily. Apply cotton sock, low stretch wrap from toes to knee including heel, in spiral fashion. Monitor	F 309		

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F 309	Continued From page 13 pressure, if too much can go back to just Tubigrip [elastic dressing]. Once a day, 6 a.m. - 2 p.m. Ulcer care right heel: Cleanse and observe daily. Protect with dry gauze for 2-4 weeks." R88's Care Plan Report from the Vascular Ulcer/Wound Healing Clinic, dated 4/11/14, read, "Continue arterial assist pump three hours daily. **Pt [patient] should have a break from wheelchair mid morning and midafternoon. ** Please make sure there is no pressure on left lateral foot wound at any time. Heel lift boot to left foot. * Keep dressing on during shower. Change dressing immediately after showering. * Check feet daily for any signs of pressure spots and/or new wounds forming. * Wear Tubigrip [elastic bandage] over entire dressing to help hold it in place. *Offload pressure areas in prevention of skin breakdown. Keep wraps on until returning to bed or elevating legs for the night. Wraps should be applied first thing in the morning before getting out of bed or allowing legs to swell." Tissue Tolerance Test done 12/9/13 read, "Resident is able to move self in bed and chair. Does have loss of sensation to feet which possibly caused skin problems." R88's care plan: Problem start date 2/20/14: "Diabetic foot ulcer with component of pressure left foot. Interventions: Follow up with wound clinic as ordered. Apply Air Assist pumps 1 hour 3 x/day while sitting up in chair. remove shoes, apply boot until heeled. Dressing per wound nurse, change daily. Wound nurse to follow until	F 309		

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healed. Monitor pain and offer pain medications as needed. Nursing to document s/s of infection daily until healed."

During an interview on 4/30/14 at 6:39 p.m., R88 stated staff had not repositioned him at all in the afternoon, just in the morning when he went to exercises. R88 stated he is able to move himself a little bit but requires staff assistance to make big changes in position. Surveyor asked R88 if he ever asked the staff to reposition him, he stated, "No, I don't want to be a bother." When surveyor asked if staff put on heel protectors when he is sitting in the wheelchair, he said, " Well, the big ones [referring to the large heel protectors] are supposed to be on when I'm up." When surveyor asked why the heel protectors were not on today while he was up, R88 stated, "They didn't get around to it." R88 stated the smaller blue heel protectors are supposed to be on when he is in bed then looked at surveyor, shrugged his shoulders and said, "I don't want to bother anyone ..."

During an interview at 10:25 a.m., on 5/1/14, the Director of Nursing (DON) confirmed that R88's heel protectors should be on when up out of bed. DON stated that the wounds on R88's feet are diabetic ulcers, not pressure, but nurses are documenting as pressure. DON stated she instructed the Registered Nurse in the nursing office to change the care plan. DON stated that R88's wheel chair foot pedals are not used at all times, and said, "He does need to keep the feet up." (DON later clarified that she meant off the floor by using the heel protectors.)

During an interview on 5/2/14 at 11:00 a.m., the nurse practitioner (NP)-A stated she was

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surprised R88 was doing as well as he is and doesn't expect the heel wounds to heal. NP-A stated R88 has a history of different types of foot and toe wounds and the wounds are taken care of by the Wound Care Clinic in Rochester. NP-A stated she had added some interventions related to R88 not propelling self in wheelchair with feet but said he does use his hands per his own choice. NP-A stated she wasn't surprised the right foot heel ulcer wound was getting worse due to multiple diagnoses.

On 5/2/14 at 1:25 p.m. LPN-A stated that on 4/30/14, she had put R88's heel protectors on during the day shift and said probably what happened was a nursing assistant had taken off the pressure wraps and forgotten to put the heel protectors back on.

On 5/2/14 at 2:41 p.m., the DON stated the wound is considered a diabetic ulcer with complications from pressure. DON stated R88 is independent in his wheelchair which complicates the ability to keep his feet elevated (to help with circulation due to diagnosis of vascular insufficiency). Surveyor informed DON about the comments from the vascular clinic nurse including the NP-A's comment stating that sitting in his wheelchair for 5 hours without the heel protectors on could have contributed to the increased size of the wound. DON stated she agreed pressure needs to be relieved by wearing the boots but does not want to limit his mobility by keeping his feet elevated. DON stated she may consider doing a risk versus benefit due to his independent choices.

Policy: Pressure Ulcers/Skin Care Policy. Reviewed policy from 2/16/14, no areas noted

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F 309	Continued From page 16 that facility are not following.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide grooming services needed for 3 of 4 residents (R81, R14, R88) in the sample reviewed for personal cares and failed to provide toileting services for 2 of 4 residents (R81, R14) reviewed for personal cares. Findings include: R81 was observed at 7:45 p.m. on 4/30/14 and was noted to have dark polished finger nails, but also to have brown debris under the nails. Family (F)-B and F-C were interviewed on 4/30/14 at 7:00 p.m. and they said they had noted R81 had lacked hand washing before meals and had dirty fingernails. F-B and F-C added the fingernails were not cleaned with baths. F-B stated the last time R81 had been hospitalized; F-B was told R81 had feces found under the finger nails. R81 ' s physician orders dated 4/1/14 noted R81 had diagnoses that included: chronic airway obstruction, mild cognitive impairment, depressive disorder, generalized pain. The annual Minimum Data Set (MDS) dated 2/18/14	F 312	Resident #81, Resident #88 and Resident #14 were provided with nail care on 5/1/2014. Their care plans were reviewed and revised as appropriate. Care plans are care sheets of residents #14, #81 and #88 were reviewed and found appropriate. Nurses and CNAs in the Dawn Neighborhood were re-educated on following the care plans for ADL assistance and toileting assistance. Also counseled on responding timely to resident's verbal calls for assistance and/or call lights. All residents, facility wide, were observed to ensure nail care was provided as appropriate. Nail care was completed on all resident nails that needed trimming and/or cleaning. All resident care plans in the EHR/POC systems revised as needed, to ensure the inclusion of nail care per qualified person. Nursing staff caring for Resident #81 and Resident #88 were reminded of care	6/11/14

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F 312	Continued From page 17 was reviewed. The BIMS (brief interview of mental status) was 10 out of 15 or moderate cognitive impairment. The MDS also indicated R81 required extensive assistance of two for bathing. R81 ' s care plan dated 5/10/12 directed R81 needed assistance with bathing/personal hygiene and that staff were to provide full assistance with nail care during bath/shower. Review of the point of care (computer program) documentation indicated weekly baths, but did not document provision of nail care. R14 was observed on 4/28/14 at 12:30 p.m. and noted to have debris under the fingernails on both hands. The physician orders dated 4/2/13 had diagnoses that included rheumatoid arthritis, hip bursitis, chronic pain, depression. The annual Minimum Data Set (MDS) dated 1/9/14 indicated R14 had a BIMS of 15 or no cognitive impairment, required extensive assistance with personal hygiene and toileting, was occasionally incontinent, and required physical assistance with bathing. The care plan dated 3/4/12 identified a problem of the resident needing extensive assistance of 1 staff for bathing and directed to provide extensive assistance of 1 staff for bathing. R88 was observed on 4/29/14 at 10:54 a.m. and noted to have long un-trimmed fingernails. The medication administration record dated 3/25/14 indicated R88 had diagnoses that included: diabetes, generalized pain, weakness. The quarterly MDS dated 3/17/14 was reviewed. R88 had a BIMS score of 15 or no cognitive	F 312	planned interventions regarding nail care on 5/1/2014. The facility utilizes Care Sheets for the CNAs that details information from the care plan which includes nail care, toileting and special interventions for ulcer prevention that can be completed by CNAs. Nurses were educated on their responsibility to ensure the CNAs complete these tasks. All nursing staff received education regarding policy and procedure on nail care and following all care plan approaches on 5/19/2014. A mandatory Nurse's meeting is scheduled for June 5th, 2014 at 1:30pm to reinforce all POC re-education. Audits for Resident #81, Resident #88, Resident #14 and facility wide random audits will be conducted to ensure care plans are followed regarding nail care weekly X4, and monthly X3 and quarterly thereafter. Audits for Resident #14 and #81 and facility wide random audits will be conducted to ensure care plans are followed regarding toileting plans weekly X4, and monthly X3 and quarterly thereafter. Audit results will be reported to the Quality Committee for further recommendations. Completion date: June 11th, 2014. Audits will be ongoing.	

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impairment, and required extensive assistance of one for personal hygiene and total dependence on staff for bathing. The care plan dated 8/28/12 had a problem of bathing/personal hygiene that directed provide full staff assistance for nail care to hands and feet weekly with bath/shower.

The facility policy entitled Shower/Tub Bath dated October 2010 read, "6. Perform nail care ..."
The facility policy entitled Care of Fingernails/Toenails dated October 2010 and signed by the director of nursing 4/16/14 read, "1. Nail care will be completed on bath/shower days, but also includes daily cleaning and regular trimming." The policy also indicated the date and time nail care was provided was to be documented.

The director of nursing (DON) was interviewed on 5/1/14 at 11:10 a.m. and stated her expectations were that fingernails were to be cleaned during showers and any time staff noticed the fingernails to be dirty. Washing of face and hands was to be done before and after meals. DON stated she did not know why fingernail cleaning was not being down. On 5/2/14 at 10:25 a.m. DON stated she would expect staff to follow the care plan.

During an interview on 5/2/14 at 11:10 a.m. nursing assistant (NA)-C stated resident fingernails were to be cleaned after baths using a wooden stick to clean them.

TOILETING SERVICES WERE NOT PROVIDED AS CARE PLANNED:
R81 was observed on 4/29/14 at 5:00 p.m. and was interviewed. At that time the resident

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complained that she was not provided toileting assistance as needed to prevent being incontinent at which time she stated, Peed in pants because I did not make it to the bathroom in time.

Family (F)-B and F-C were interviewed on 4/30/14 at 7:00 p.m. and they both said they came in to visit R81 every evening to help their mother. They would help get R81 to and from the toilet and help R81 get ready for bed because they felt staff was not providing these cares timely.

The physician orders dated 4/1/14 noted R81 had diagnoses that included: recurrent dysuria (painful urination), cystitis (bladder infection), mild cognitive impairment, generalized pain. The annual Minimum Data Set (MDS) dated 2/18/14 was reviewed. The BIMS (brief interview of mental status) was 10 out of 15 or moderate cognitive impairment. The MDS also indicated R81 required extensive assistance of two staff for toileting. The care plan dated 3/15/13 indicated R81 needed toileting assistance every two hours and was at times incontinent of bladder.

During an interview on 5/2/14 at 10:25 a.m. the DON stated she would expect staff to follow the care plan.

R14 was observed on 4/28/14 at 6:15 a.m. crying and said, "Take me to bathroom please!" R14 was observed to be restless while in bed. No staff entered room to help her until 6:23 a.m. then staff wheeled her to the shower room. On 4/30/14 at 3:10 p.m. R14 was observed lying in bed and again was crying "Help me!" The room had a foul odor of stool. At 3:15 R14 continued to call out

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F 312	Continued From page 20 "Help me!" At 3:35 p.m. (a period 25 minutes of crying before any staff checked resident ' s crying) nursing assistant (NA)-A entered room and prepared to transfer R14 to chair, but did not check R14 for incontinence or offer toileting services. At 3:50 p.m. R14's visitor asked staff to please take R14 to the bathroom and at 3:58 p.m. the registered nurse (RN)-E coordinator told a nursing assistant that R14 needed to use the bathroom. At 4:05 p.m. (a total of 55 minutes from the time R14 started crying for help staff checked incontinence product) NA-A and NA-B were observed to check R14 ' s incontinence brief at which time they changed a soiled incontinence brief. The physician orders dated 4/2/13 had diagnoses that included rheumatoid arthritis, hip bursitis, chronic pain, depression. The annual MDS dated 1/9/14 indicated R14 had a BIMS of 15 or no cognitive impairment, required extensive assistance with toileting, was occasionally incontinent of urine. The care plan dated 4/3/14 had a goal of " resident will continue to assist with toileting. " The care plan directed offer toileting every 2 to 3 hours; provide extensive assist of 1 to transfer/clothing management/hygiene for toileting. On 5/2/14 at 10:25 a.m. the director of nursing stated she would expect staff to follow R14 ' s care plan.	F 312		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325		6/11/14

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F 325	Continued From page 21 (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a renal diet with low potassium foods as recommended by the dialysis unit for 1 of 1 resident (R137) reviewed for dialysis cares. Findings include: R137 was observed during the noon meal on 5/1/14 at 12:30 p.m. R137's meal consisted of an 8 ounce glass of chocolate milk, roast beef, mashed potatoes, whole wheat bread, and gravy. R137 ate approximately 75% of the meal including all mashed potatoes with gravy, milk, and bread. However, the milk, bread and gravy were not to be served to R137 as they are restricted from the physician ordered renal diet. The physician orders dated signed 4/16/14 listed diagnoses that included: fluid overload, end stage renal disease (ESRD). The Mayo Clinic Dialysis Services Memorandum of Understanding dated March 2014 directed the facility dietician was to contact the dialysis clinic dietician. No documentation of the discussion between the two dieticians was found or provided	F 325	Resident #137 discharged to home with hospice services. For any new residents coming to us on a renal diet we will be listing it on their diet card as Renal Diet (low potassium, low phosphorus and low sodium). Currently we no longer have any residents on this diet, but moving forward we will use this. I also provided nutrition information from out diet manual from the Academy for Nutrition and Dietetics to each neighborhood kitchen listing food items that need to be limited to once every 24 hours. To protect all of the residents currently in our facility the CDM went through all of their diets and double checked them against what was in the diet program. All diets are now current and listed the same as our diet manual and menu program. This will help to ensure all residents are receiving their correct diet. Measures we will take to ensure our new process will work the CDM has a staff education will take place on 5/23/2014 at our Culinary staff meeting. Also when we	

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F 325	Continued From page 22 when requested. The Nutrition Assessment dated 3/11/14 read, "no present concerns with the meal service. " Renal level 2 with thick liquids as current diet order. Under nutritional diagnostic statements the registered dietician noted: "increased needs for protein related to ESRD on dialysis" and impaired ability to chew/swallow, need for texture modified diet. The interdisciplinary notes of 4/23/14 stated R137 was to receive a dysphagia 2 and mechanical soft diet. Neither the interdisciplinary notes nor the nutritional assessment identified the recommendations to limit high phosphorous foods. The laboratory Progress Report for Mayo Clinic Dialysis Services dated 4/18/14 was reviewed. On 4/16/14 R137 had a phosphorus level of 6.3 (normal 3.0 to 5.50) which was high level in blood stream. Comments included limit high phosphorus foods like milk, cheese, nuts, dried beans, whole grain foods, chocolate and cola. The care plan dated 4/9/14 listed nutritional status. ESRD listed interventions that included "per dialysis recommendations limit high phosphorous foods, such as nuts, milk, cheese, dried beans, whole grains, chocolate and cola." The General Flow sheet dated 4/1/14 indicated a diet order dated 4/23/14 for limit high phosphorus foods such as nuts, milk, cheese, dried beans, whole grains, chocolate and cola. The culinary assistant-A provided a copy of Chronic Kidney Disease Stage 5 Nutrition Therapy adapted from National Renal Diet. The multipage diet choices was not individualized for R137 to direct dietary staff the number of	F 325	have this diet again the CDM will be providing education to the staff in that area reminding them about the renal diet and showing them where they can double check what they should/shouldn't have. The CDM plans to monitor this process by doing daily checks for 7 days once our facility receives a renal diet. After 7 days the CDM will do random weekly checks. These daily/weekly checks will include talking with staff, the resident and their family. This will help to ensure we are meeting the residents needs and help our staff with any questions they are having about this diet. The CDM will also be talking with the cooks about making sure they are following the extensions provided from our menu program which coincides with our diet manual from The Academy of Nutrition and Dietetics. These new processes and measures will be fully completed on June 11th, 2014 after a staff meeting, but processes to change our renal diet approach started on May 5th, 2014.	

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F 325	Continued From page 23 servings for protein, fruit and vegetables, potassium, phosphorus , bread and grains. The culinary assistant also provided a Renal Diet from New Hanover Health Network that listed foods not allowed. This food list indicated no dairy except for cream cheese and sherbet, no whole grain breads. The facility menus were requested and provided for the week of May 25, 2014. However, review of these menus indicated a renal diet was not to receive milk except for morning cereal and no gravy. R137 ' s dietary tray card used by the cook to serve meal choices stated renal diet, but did not indicate low potassium, no milk, no chocolate, no nuts, any whole grain breads, etc. On 5/2/14 at 10:35 a.m. the director of nursing stated she would expect staff to follow the care plan. On 5/2/14 at 10:30 a.m. the culinary assistant-A was interviewed and verified the tray card did not include limiting phosphorus foods, but added the dietary aids had access to the renal diet guidelines on each unit. 37 to direct dietary staff the number of servings for protein, fruit and vegetables, potassium, phosphorus , bread and grains. The culinary assistant also provided a Renal Diet from New Hanover Health Network that listed foods not allowed. This food list indicated no dairy except for cream cheese and sherbet, no whole grain breads. The facility menus were provided for the week of May 25th-not current week ' s menu. However, review of these menus indicated a renal diet was not to receive milk except for morning cereal and	F 325		

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F 325	Continued From page 24 no gravy. The dietary tray card stated renal diet, but did not indicate low potassium, no milk, no chocolate, no nuts, no whole grain breads, etc. On 5/2/14 at 10:35 a.m. the director of nursing stated she would expect staff to follow the care plan. On 5/2/14 at 10:30 a.m. the culinary assistant was interviewed and verified the tray card did not include limiting phosphorus foods, but added the dietary aids had access to the renal diet guidelines on each unit.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		6/11/14

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F 329	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify parameters for use of as needed (PRN) pain medications, to document non-pharmacological interventions and effectiveness for PRN psychotropic and pain medications for 1 of 5 residents (R13) reviewed for medication use. Findings include: R13 received PRN pain medications however, there had not parameters identified for use of the medication. Also there was no monitoring to determine if non-pharmacological interventions or if psychotropic or pain medications were effective for R13. R13 was admitted to the facility on 4/13/14 with diagnoses including: cellulitis/abscess right fourth finger, chronic pain, chronic kidney disease, and anxiety state per the face sheet. R13's current physician orders dated 4/16/14 included PRN orders for the following pain and psychotropic medications: "Tramadol tablet; 50 mg [milligrams]; amt [amount]: 25 mg; oral. Every 6 hours- PRN; PRN 1, PRN 2, PRN 3, PRN 4" "Acetaminophen tablet; 500 mg; amt: 1000 mg; oral. Special Instructions: Maximum acetaminophen dose; 4000 mg in 24 hours. Please note resident has a PRN Norco order.	F 329	Resident #13 had no negative outcomes from the identified practice. Care plan was reviewed and updated and plan is in place to adequately identify, assess and monitor clinical indications for the use of psychoactive medications. Medication trials were stopped immediately. Any trial of medication will be ordered per the physician or CNP and all necessary documentation will be completed. A form will be utilized for all residents receiving psychopharmacological medications on a PRN basis. The form will include targeted behaviors and nonpharmacological interventions and placed into the Medication Administration Record and care plan. Proper documentation will be completed. Care plans will be updated as nonpharmacological interventions are identified. Re-education will be given to all licensed nursing staff on policy and procedures for following use of PRN medications including the identifying parameters for use of PRN pain and/or psychotropic medications, reinforcing completion of proper documentation for targeted behavior seen, nonpharmacological interventions tried and response to the intervention. If the nonpharmacological	

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F 329	Continued From page 26 TID: Three Times a Day; 8:00 AM, 2:00 PM, 8:00 PM" "Norco (hydrocodone- acetaminophen) - Schedule III tablet; 5-325 mg, amt: 1-2 tabs; oral. Special Instructions: For moderate pain. Maximum acetaminophen dose; 4000 mg in 24 hour period. Every 4 Hours - PRN; PRN 1, PRN 2, PRN 3, PRN 4, PRN 5, PRN 6." "Ativan (lorazepam) -Schedule IV tablet; 0.5 mg; amt: 0.5 mg; oral. Every 6 hours- PRN; PRN 1, PRN 2, PRN 3, PRN 4." Review of the Medications administration record (MAR) dated 4/18/14- 5/18/15 the following was written: "Trial nurses order Ativan 0.5 mg PO [by mouth] TID for anxiety. 0600, noon, 6 pm (HS) [evening] " From 4/17/14 to 4/23/14 R13 received the scheduled Ativan 19 times during this trial. "Trial nurses order Tramadol 25 mg 1 PO [by mouth] TID [three times a day] (1wk) [1 week]. 0600, noon, (6 pm) HS." From 4/17/14 to 4/23/14, R13 received the scheduled tramadol 19 times during this trial. "Trial nurses order Ativan 0.5 mg one PO BID [twice a day] for anxiety.) 0700, HS." From 4/24/14 to 4/29/14, R13 received the scheduled Ativan 12 times during this trial. Review of the April 2014 MAR showed the following: R13 received PRN Ativan seven times from 4/4/14 to 4/16/14. The facility did not document	F 329	intervention fails and medication is given, all PRN medications, targeted behavior for use and response to pharmacological intervention must be documented. A mandatory Nurse's meeting is scheduled for June 5th, 2014 at 1:30pm to reinforce all POC re-education. Resident #13 medication regimen will be monitored by the DON or designee, through audits weekly X4, monthly X3 and quarterly thereafter. DON, or designee will conduct facility wide audits of all resident PRN medication use through record review monthly X3 and quarterly thereafter, to assure residents' medication regimens are free of "trials", unnecessary medications with an emphasis on monitoring and proper documentation. All medications ordered for each resident, including psychotropics will continue to be reviewed by facilities Consulting Pharmacist monthly. Audit results will be reported to the Quality Committee for further recommendations. Completion date: June 11th, 2014. Audits will be ongoing.	

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F 329	Continued From page 27 the effectiveness of the PRN Ativan 4 of the 7 times the medication was administered. During the nurse ' s trial of scheduled Ativan 0.5 mg TID from 4/16/ 14 to 4/23/14, R13 received Ativan 19 times with no documentation of reason to give or the effectiveness or the effectiveness of the medication administered. During the nurses trial of scheduled Ativan 0.5 mg BID (twice a day) from 4/24/14 to 4/29/14 0.5 mg R13 received the Ativan twelve times with no documentation of reason to give or effectiveness of the medication administered. In addition the facility failed to consistently document non-pharmacological interventions attempted prior to the PRN and scheduled nurses trial of the Ativan being administered for the month of April 2014. R13 received PRN Norco twenty-two times from 4/4/14 to 4/28/14. The facility did not document the effectiveness of the PRN Norco 22 of the 22 times the medication was administered. The facility did not document the reason for use 1 of the 22 times the medication was administered. In addition the facility failed to consistently document non-pharmacological interventions attempted prior to the PRN Norco being administered. R13 received PRN Tramadol eleven times from 4/6/14 to 4/14/4. The facility did not document the effectiveness of the PRN Tramadol 11 of the 11 times the medication was administered. The facility did not document the reason for use 1 of 11 times the medication was administered. During the nurse ' s trial of scheduled Tramadol 25 mg TID (three times a day) from 4/27/14 to 4/23/14, R13 received Tramadol nineteen times with no documentation of reason to give or effectiveness of the medication administered. In addition the	F 329		

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F 329	Continued From page 28 facility failed to consistently document non-pharmacological interventions attempted prior to the PRN and scheduled nurses trial of the Tramadol being administered for the month of April 2014. Review of the Medication Administration- General Guidelines dated 2006 policy read, 2) "Medications are administered in accordance with written orders of the attending physician." C. Documentation... 5) "When PRN medication are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and if applicable, the injection site. b. Complaints or symptoms for which the medication was given c. Results achieved from giving the dose and the time results were noted." During an interview on 5/1/14 at 10:46 a.m., the director of nursing (DON) stated her expectation was for the facility to obtain a physician's order to complete a trial of an antianxiety medication prior to the medication being administered. The DON shared trials of medications without a physician's order had been facility practice and this practice had been stopped effective immediately. During an interview on 5/2/14 at 7:56 a.m. registered nurse (RN)-D verified the PRN pain medications for R13 did not provide parameters for use. RN-D verified nursing was to attempt and	F 329		

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F 329	Continued From page 29 document non-pharmacological interventions used prior to administering PRN pain and psychotropic medications. RN-D verified nursing was to document the effectiveness of the PRN pain and psychotropic medications. RN-D verified as evidenced by the MAR and progress notes nursing did not consistently document the effectiveness of the PRN medications or document attempted non-pharmacological interventions used prior to administering PRN psychotropic and pain medications for R13. Verified facility did not follow the policy for administering prn medications consistently. During an interview on 5/2/14 at 8:13 a.m., the director of nursing verified there were no parameters in place for the use of the PRN pain medications for R13. The DON verified staff would need to use nursing judgment to determine which PRN medication to administer. The DON stated she expected staff to attempt non-pharmacological interventions prior to giving PRN pain or psychotropic medications. The DON stated documentation should be completed of the non-pharmacological interventions tried and symptoms being displayed prior to administration of the PRN medications. The DON stated after the medication was given, the nurse needed to document the effectiveness of the medication. The DON verified facility did not have documentation of non-pharmacological interventions or follow up for the effectiveness of the PRN pain or psychotropic medications on a consistent basis. Stated she would expect this documentation to be completed each time a PRN medication was given to a resident with follow up to the physician. In addition the DON verified the facility was not following their policy for PRN medication administration.	F 329		

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F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staff to complete resident cares in a timely manner for 6 of 21 residents (R156, R84, R88, R65, R158, R155, R81) and to meet the resident assessed needs for 3 of 4 residents (R137, R88, R156) with acute needs. This had the potential to impact all 69 residents in the facility. Findings include: Complaints of inadequate staffing were received	F 353	Staffing Coordinator re-educated on 5/18/2014 to ensure replacement of staff if there are call-ins and to enforce the Union Mandating Policy if staffing levels fall too low. With guidance from the Director of Nursing, the Staff Scheduler is responsible for scheduling to assure that adequate nursing staff are available to meet the residents' care needs. In the absence of the scheduler, the Charge Nurse is responsible for utilizing the "Starred" system for emergency staffing	6/11/14

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F 353	Continued From page 31 from residents, family members, staff, from people who asked to speak with the surveyors (who wanted to remain anonymous), and from a review of Office of Health Facility Complaints concerns and ombudsman concerns. Residents voiced concerns that staff were unavailable or did not answer call lights, and did not meet their needs for 6 of 21 residents reviewed (R156, R84, R88, R65, R158, R155, R81). Families voiced concerns that staff were not available and need not meet the needs of residents for 4 of 7 family members interviewed (FM-B, FM-C, FM-D, FM-E) Lack of services and cares as required for each residents assessed needs: See F312, Based on observation, interview, and document review, the facility failed to provide grooming services needed for 3 of 4 residents (R81, R14, R88) in the sample reviewed for personal cares and failed to provide toileting services for 2 of 4 residents (R81, R14) reviewed for personal cares. See F282, Based on observation, interview, and document review the facility failed to provide grooming services in accordance with the plan of care for 2 of 4 residents (R81, R88) in the sample reviewed for personal cares; failed to provide toileting services in accordance with the plan of care for 2 of 4 residents (R81, R14) reviewed for personal cares; and failed to provide care in accordance with the plan of care for 1 of 1 residents (R88) reviewed with diabetic ulcers. See F425, Based on observation, interview and document review, the facility failed to ensure that new medication was obtained for one of six	F 353	needs. Attendance policy has been reviewed with all staff on 5/21/2014 and staff educated on need to come to work as scheduled unless they have an infectious process that inhibits them from working. A meeting was held on 5/14/2014 for all CNAs to attend to discuss ideas for improving staffing concerns/needs. Director of Nursing lead and team meeting with 4 CNAs in attendance. Staffing patterns were reviewed and ideas were discussed on reallocating hours for maximum efficiency and efficacy. Planning and revising of schedules with reallocation of hours will be implemented as new CNAs are hired. Universal workers are utilized during mealtime. Staff absenteeism will continue to be tracked; Employee handbook policies relating to attendance issues will direct counseling and/or corrective actions. DON and neighborhood RN Coordinator will monitor the facilities census and acuity level to ensure appropriate staffing levels. LSW will interview Residents #156, #84, #88, #65, #158, #155, and #81 weekly X4 and monthly X3 regarding satisfaction with cares and services. Concerns will be communicated to the administrator and IDT as appropriate. LSW will monitor family/resident satisfaction during care conferences, surveys, resident and family council meetings and interviews. The DON and nursing management staff will continue to respond to resident/family concerns regarding nursing care and	

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F 353	Continued From page 32 residents (R156) in a timely manner. See F309, Based on observation, interview and document review, the facility failed to provide necessary services for 1 of 1 resident (R137) who received dialysis services and failed to provide services for optimal healing of a diabetic wound for 1 of 2 residents (R88) with an open wound. Resident ' s concerns with getting timely assistance: During phase I resident interviews, 6 or 20 residents complained of staffing issues. In addition other residents also spoke with the surveyors related to staffing issues. R156 was a new admission on the rehabilitation unit. R156 was interviewed on 4/28/14 at 11:33 a.m. and stated the facility could use more staff. R156 stated a couple of nights ago she had the call light on and asked for pain medications, but the male staff person never returned. An hour and a half later R156 again turned on her call light. A different staff member responded and provided the medication. R84 resided on the long term care unit. The quarterly Minimum Data Set (MDS) dated 3/13/14 was reviewed. R84 had diagnoses that include cardiac concerns, diabetes, dementia, depression. R84 required extensive assistance with all activities of daily living (ADL). On 4/28/14 at 12:43 p.m., R84 stated he did not feel there was enough staff to help him when he needed the help. R88 resided on the long term care unit. The quarterly MDS dated 3/17/14 was reviewed. R88	F 353	services. Scheduling Coordinator, DON, Administrator and HR Director will meet and discuss recruiting and retention efforts. Then administrator will review staffing levels, scheduling patterns and investigate complaints as they arise. The administrator will report/discuss compliance at the Quality Meeting on an ongoing basis to achieve positive outcomes. A staffing plan/model will be developed to assist in meeting resident needs. The model will be developed by the Staffing Coordinator/DON/ADM. This will be monitored by the DON, Staffing Coordinator and Administrator.	

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was not cognitively impaired, required extensive assistance with ADLs, experienced pain, and had diagnoses that included heart failure and diabetes. During an interview on 4/29/14 at 10:52 a.m. R88 stated staff were sometimes very busy and would tell him they did not have time to help him and would have to wait long periods of time.

R65 resided on the long term care unit. The quarterly MDS dated 3/21/14 was reviewed. R65 was not cognitively impaired, required extensive assistance with ADLs, experienced pain, and had diagnoses that included multiple sclerosis. During an interview on 4/29/14 at 9:18 a.m., R65 stated staff that was cross trained was not on the units to help out nursing assistants. He felt that some days there was only one nurse to help 48 residents and so that nurse had to do some running. R65 stated that he had to wait 30 minutes to have the call light answered. Most of the time R65 said he would just sit on the commode until someone would come to help him no matter how long it took. R65 stated he was to use the E/Z stand, but that most do not take the time to help him with using it.

R158 was a new admission to the rehabilitation unit. R158 was interviewed on 4/29/14 at 1:50 p.m. R158 stated she did not feel there was enough staff to help her, especially on weekends. Last weekend R158 stated she had to wait for up to 2 hours to receive an ice pack for pain.

R155 was a new admission to the rehabilitation unit. R155 was interviewed on 4/29/14 at 11:22 a.m. She stated she felt there could be more staff to help the residents.

R81 resided on the long term care unit. The

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F 353	Continued From page 34 annual MDS stated 2/18/14 indicated R81 was moderately cognitively impaired, required extensive assistance with ADLs, experienced pain, was occasionally incontinent, and had diagnoses that included diabetes and COPD. During an interview on 4/29/14 at 5:00 p.m., R81 stated that she had to wait for the call light to be answered and sometimes while waiting "Peed in pants because did not make it to bathroom in time." R81 stated only a couple of people work the overnight shift and it is not enough. Family Concerns with loved ones cares and services being completed timely and or adequately: Family member (FM)-D was interviewed on 4/28/14 at 11:33 a.m. and stated she had been in (requested residents identity not be identified) needed to go to the bathroom. FM-D stated after a 20-30 minute wait FM-D went into the hall to locate a staff member and found two nursing assistants just chatting. FM-D stated she felt the facility was short staffed during meal times. FM-B and FM-C were interviewed on 4/29/14 at 7:00 p.m. They stated the call lights could take 45 minutes to be answered and that they felt the need to be with their (family does not want resident identified) every evening to make sure the resident was toileted and dressed for bed. They also felt their (resident not identified per family request) lacked the necessary cares like baths, finger nails, and hand washing. FM-E was interviewed on 5/2/14 at 9:30 a.m. FM-E stated she was concerned with how short staffed the facility was. She stated a nursing	F 353		

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F 353	Continued From page 35 assistant told her the facility did not have enough staff and that management was aware and seemed not to care as it never gets better. Staff Interviews with concerns in getting resident cares and services completed timely: On 4/28/14 at 6:15 a.m. nursing assistant (NA)-D was interviewed. She stated the long term care unit was to be staffed with three nursing assistants. NA-D stated that sometimes staff called in and were not replaced. She stated that had most recently happened the previous day. NA-D stated the residents did not get walked yesterday and staff did not get lunch because they were so busy they just couldn't get everything done. On 4/28/14 at 6:37 a.m. licensed practical nurse (LPN)-A was interviewed. LPN-A stated today the long term care unit only had 2 nursing assistants because a nurse and a nursing assistant called in. LPN-A stated the unit should have 3 nursing assistants. LPN-A stated that sometimes the residents do not get timely assistance with eating, range of motion, or walked. Last Thursday no resident was walked that required it and no daily weights were done. The other day a resident's family assisted the resident to eat breakfast at 11:00 a.m. because staff had not gotten to them timely. NA-E was interviewed on 4/28/14 at 6:37 a.m. She stated that 90% of the time the unit (rehabilitation) only had 2 nursing assistants and then at times they needed to go help on another unit. If they needed help, the nursing assistants would let the nurse know and the nurse would try to get help from another unit.	F 353		

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NA-F was interviewed on 4/28/14 at 6:09 a.m. and indicated staffing has been " tough. " In the many years she had been a nursing assistant she had never seen it this bad. NA-F stated she always feared the State coming but this year it was a relief because they may be able to help with poor staffing. NA-F stated she is running to get all the work done, but thinks she meets the resident needs, but at times she does not get a break. At time NA-F stated there would only be one nursing assistant for the two rehabilitation units because of call ins so will have to pull a nursing assistant from another unit. NA-F stated she felt this was no longer a resident centered facility or one that puts the residents first.

Call light audits:

The facility provided call light audits for one long term care unit for the time period of April 1, 2014 to April 14, 2014. The facility was unable to provide additional data related to computer system problems. The reports indicated that on the Aspen unit the call light alarms were triggered 904 times and of that 127 times exceeded 16 minutes (range 16 minutes to 75.5 minutes) or 14% of the time the residents needed to wait greater than 16 minutes to receive help.

The director of nursing (DON) was interviewed on 5/1/14 at 11:24 a.m. The DON stated she was aware that there had been a lot of complaints related to staffing. DON thinks the facility needs to look at staffing patterns, more than numbers only. DON stated there was a process for call ins that required a nurse or nursing assistant to stay an additional 4 hours after the completion of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 37 her/his shift and then the facility would try to find a replacement. DON stated there have been issues related to staffing and cares not being done. There are actually several universal workers that could help with feeding, but they do not work during the evening. Always have a nurse in the building and on overnights. DON stated call lights should be answered in 5 to 15 minutes. The administrator was interviewed on 5/2/14 at 12:45 p.m. He verified he was aware of scheduling and staffing issues and at times has needed to put new admissions on hold. Stated the facility has utilized pool staffing but at times that system also fails. On 5/2/14 at 2:14 p.m. the DON stated she felt the facility needed to work on call light issues, staffing issues, and resident personal care issues.	F 353		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		6/11/14

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	245426	A. BUILDING _____ B. WING _____	05/02/2014

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F 425	Continued From page 38 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that new medication was obtained for one of six residents (R156) in a timely manner. Findings include: Observed the Licensed Practical Nurse (LPN)-C during medication administration on 5/2/14 at 8:00 a.m. At 8:10 a.m. LPN-C was preparing medications for R156 and reported that she did not have the new medication metoprolol tartrate 25 mg (used to treat hypertension and heart failure) which was ordered 5/1/14 by the physician and was to be given twice daily. LPN-C reported that she worked the night shift and had to stay late after her shift and was sure the medication order was faxed to the pharmacy but that the delivery had not yet come in time for the morning pass. The physician order on the Referral form dated 5/1/14 notes, "Recommend increasing Lasix to 20 mg twice daily and reintroducing metoprolol tartrate at 25 mg twice daily. Recheck K+ [potassium] & Creatinine next Monday. Otherwise per followup with Dr. [doctors name]." During an interview on 5/2/14 at 10 a.m. with	F 425	Medication for Resident #156 was obtained from the pharmacy on 5/2/2014 and resident received on 5/2/2014. No adverse effects were noted due to missed medication. Resident has discharged to home. Due to the recent change over of pharmacies from Allina to Weber and Judd on 5/1/2014 and all the efforts it took to ensure a smooth transition, a review of all ordered medications were checked and all others were received and administered as ordered. DON spoke with Pharmacist at Weber and Judd to discuss F425. it was confirmed that if an order is received after the "cut off" time and evening driver is in route, nursing staff will fax the order then call the 24-hour emergency number for Weber and Judd, which is posted on all neighborhoods. The pharmacy has committed to bringing the medication on an immediate delivery. If nurse is unable to obtain medication and it is not available in the E-kit, the physician must be notified and a hold order will be obtained and processed. All licensed nursing staff were	

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F 425	Continued From page 39 R156, she reported that she returned from the cardiologist appointment in Rochester around supper time last evening. She also verified that the new medication had not yet been administered to her. During an interview 5/2/14 at 11:15 a.m. with the registered nurse (RN)-B, the neighborhood coordinator, she was unable to verify if the new medication order had been faxed to the pharmacy the prior evening. She reported that the nurse that had just come on had faxed the order and called the pharmacy to verify if the medication order had been faxed. During an interview on 5/2/14 at 11:30 a.m. with LPN-B it was verified that she had checked with the pharmacy after she came on duty at 10 a.m. today and she reported that the pharmacy said their delivery person was already on the way the night before, therefore it would be delivered with this morning ' s delivery. The document titled Medications Flow sheet dated for May 2014 indicates that the metoprolol tartrate had not been given as of noon on 5/2/14. The document titled Medication Ordering and Receiving from Pharmacy that is a part of Weber and Judd Company Policies and Procedures Manual, page 21 read, "3) New medications, except for emergency or "stat" medications, are ordered as follows: a. If needed before the next regular delivery, phone or fax the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery. b. Timely delivery of new orders is required so that medication administration is not delayed. The emergency kit is used when the resident needs a	F 425	re-educated on 5/14/2014 regarding the facilities policy and procedure for Medication Ordering and Receiving from Weber and Judd and expectations if it is not received. A mandatory Nurse's meeting is scheduled for June 5th, 2014 at 1:30pm to reinforce all POC re-education. Facility wide random audits will be conducted by the DON or designee will be done weekly X4, monthly X3 and quarterly thereafter to ensure timely ordering and receiving of medications. Negative audits will be reviewed with nursing and pharmacy staff as appropriate followed with re-education and/or corrective action. Audit results will be reported to the Quality Committee for further recommendations. Completion date: June 11th, 2014. Audits will be ongoing.	

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F 425	Continued From page 40 medication prior to pharmacy delivery." The document from Weber and Judd Company listing the Emergency med kit (e-kit) list for the Kindle neighborhood was reviewed and did not include metoprolol. The document from Weber and Judd titled Weber & Judd Nursing RX lists the times of operation, phone and fax numbers and emergency service numbers for the pharmacist on call. During an interview on 5/2/14 at 11:30 a.m. RN-A said that their pharmacy is Weber and Judd and that the emergency number is to be called if they need a drug that is not in the e-kit even if it is not an emergency drug. They will deliver it if requested. She said it must be specifically requested. She also verified that the procedure was the same as the previous pharmacy supplier (who was Allina pharmacy.) During an interview 5/2/14 at 11:50 a.m. with the director of nursing she indicated that there were process issues and that the staff has been educated on Weber and Judd pharmacy procedures recently. She also verified that she would have expected the pharmacy to be called with the new medication order for R156 so that it could have been started this morning.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		6/11/14

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F 431	Continued From page 41 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to secure medications appropriately. Findings include: On 4/30/14 at 5:12 p.m. R64 was observed to have registered nurse (RN)-A approach her to receive insulin ordered to be given before supper.	F 431	Insulin belonging to Resident #64 was destroyed on 4/30/2014 and a new vial of insulin was ordered, received and locked within medication cabinet in Resident #64's room. Resident rooms' facility wide were checked for unlocked medications.	

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F 431	Continued From page 42 RN-A was unable to find the insulin in the locked medication cupboard in R64's room. The Novolog insulin and a syringe were found unsecured on top of the medication cupboard. RN-A stated the insulin should be in a locked cupboard and was not, and then proceeded to give the injection and place the extra syringe in the cupboard. On 4/30/14 at 5:15 p.m. RN-A stated she should not have given the insulin since it had not been stored properly. RN-E, unit coordinator stated she did not know why the insulin was on top of the cupboards and stated it should not have been given. On 5/1/14 at 11:25 a.m. the director of nursing stated the insulin should not have been given since did not know if the medication had been tampered with.	F 431	Proper corrective action was taken for any medications found outside locked medication cabinets. Unfortunately, the Surveyor who witnessed the inappropriate use of improperly stored medication did not stop the employee from administering medication to Resident #64. RN-A immediately recognized her mistake after administering and verbalized her error to the surveyor. RN-A was re-educated on policy and procedure pertaining to proper storage and locking of medications and not using any medication that is found improperly stored. A mandatory Nurse's meeting is scheduled for June 5th, 2014 at 1:30pm to reinforce all POC re-education. RN-A is voluntarily terminating employment on 5/23/2014. Resident #64's medication storage will be audited weekly X4, monthly X3 and quarterly thereafter. Facility wide random audits will be conducted by the DON or designee ensuring proper locking and storing of all medications, weekly X4, monthly X3 and quarterly thereafter. Audit results will be reported to the Quality Committee for further recommendations as needed. Completion date: June 11th, 2014. Audits will be ongoing.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		6/11/14

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F 441	Continued From page 43 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 441	During Resident #14's wound dressing	

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F 441	Continued From page 44 review, the facility failed to ensure aseptic techniques were used during changing of wound VAC (vacuum assisted closure) and dressing for 1 of 1 resident (R14) observed with a wound VAC. Findings include: R14 was observed during the changing of the wound VAC (A wound VAC [vacuum assisted closure] is a device which allows people to conduct negative pressure wound therapy [NPWT]. The device consists of a dressing which is fitted with a tube and attached to the wound VAC. Negative pressure wound therapy is most commonly used with chronic wounds which are not responding to other forms of treatment, and sometimes with surgical wounds which have reopened. It usually requires the supervision of a nurse, although people do not need to be hospitalized to use a wound VAC) on 4/30/14 from 6:10 p.m. to 7:00 p.m. R14 was readmitted to the nursing home on 4/17/14 and had physician's orders that listed diagnoses including: wound, open lower limb with complications. R14 had a physician's order dated 4/28/14 " wound vac to wound on right leg upper 2 wounds only. Dr. [name of doctor] will change at clinic every Monday and KODA to change every Thursday." On 4/30/14 at 6:10 p.m. Licensed practical nurse (LPN)-C stated the wound vac to R14's right leg needed to be changed related to the loss of suction when the tube hose came loose and was not able to be resealed. Registered Nurse (RN)-E was observed to bring a	F 441	change on 4/30/2014, procedure was stopped due to breech in aseptic technique. New scissor was obtained, contaminated dressing was disposed of and new dressing was used. Dressing change continued with Resident #14's wound dressing change administered in accordance with physician's orders and facility policy using aseptic technique. As the facility recognizes the potential for this alleged deficient practice to affect other residents, the DON re-educated all licensed nurses regarding cleaning and disinfecting of reusable equipment on 5/20/2014. Wound nurse, LPN was counseled and retrained regarding proper cleaning and disinfecting of reusable equipment and aseptic technique. Education included verbalized understanding. Wound nurse, LPN has been evaluated by the DON for competency of professional standards and has been found to meet those standards. A mandatory Nurse's meeting is scheduled for June 5th, 2014 at 1:30pm to reinforce all POC re-education. To ensure continued compliance with proper aseptic technique and disinfection of equipment, the DON or designee will complete infection control round audits weekly X4 and monthly X3 and quarterly thereafter. Three of those audits will be completed on LPN Wound nurse during wound rounds. Audit results will be reported on the Quality Committee for further recommendations.	

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F 441	Continued From page 45 scissors into the room for LPN-C to use during the dressing change. RN-E carried the uncovered scissors with the tip/blades in the flat of her hand. No gloves on. She placed the scissors on a binder on the over bed table. LPN-C removed the dressings with gloves on. RN-E wearing gloves measured the wounds. Director of Nursing (DON) placed a clean hand towel on the bed and over bed table. Gloves were changed by LPN-C and RN-E. The sterile saline container was opened by RN-E and an unsterile 4X4's were used by LPN-C to dab the lower wound area. LPN-C was observed to wipe the entire area with one gauze and not wipe clean to dirty areas in sequence. The upper wound was cleaned using a syringe to place sterile saline into the wound and then dabbed with an unsterile 4 X 4 by LPN-C, again not using the clean to dirty sequence for dabbing. At 6:21 p.m. LPN-C cut the wound vac dressing over the sterile foam inner dressing with the scissors brought in by the nurse and not sanitized before using. Before the scissors could be used the surveyor asked the nurse to determine if the scissors should be sanitized before using. The DON nodded yes to the question and that the wound dressing and everything else needed to be replaced with a clean dressing kit including the tubing that was laying in the bag of contaminated supplies. At 6:24 p.m. the DON stated this was not a sterile procedure but that everything needed to be very clean and proceeded to washed the scissors off in the sink with running water and wiped with an alcohol preparation pad. At 6:26 p.m. LPN-C brought in a sterile scissors. The DON	F 441	Completion date: June 11th, 2014. Audits will be ongoing.	

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F 441	Continued From page 46 completed the dressing change. The policy/procedure entitled Dressings; Dry/Clean dated October 2010 and signed by the director of nursing 2/16/14 was reviewed. The Policy read, " 12. Using clean technique, open other products " . The policy also stated " 16. Cleanse the wound. Use a syringe to irrigate the wound, if ordered. If using gauze, use a clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward.)" On 5/1/14 at 11:18 a.m. the director or nursing verified an infection control breach had occurred during R14 ' s dressing change and added I have a lot of education to do.	F 441		

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	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**04/30/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this initial survey, KODA Living Community was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2014

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. KODA Living Community is a 1-story building with no basement. The original building was constructed in 2013 and was determined to be of Type V (111) construction. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection in the corridors, spaces open to the corridors, and all residents sleep rooms that is monitored for automatic fire department notification. The facility has a capacity of 79 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit	K 017		6/11/14

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K 017	Continued From page 2 the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain projections into the corridor that meet the requirements of CMS - S&C-10-18-LSC per the 2009 NFPA 101 LSC 18.2.3.4. This deficient practice could affect 15 out of 67 residents Findings include: On facility tour between 10:45 AM and 4:45 PM on 04/30/2014, observation revealed that the Automatic External Defibrillator (A.E.D) cabinets project more than 6 inches (measured 7-1/2 inches) into the corridors of the following areas: 1. Aspen wing 2. Dawn wing These deficient practices were confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 017	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. AED's were relocated from the corridor/egress area on 5/7/2014. All corridor areas of egress will be monitored by the facility Maintenance Director. Correction completed by 5/21/2014.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1	K 029		6/11/14

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	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**04/30/2014**

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 hour fire rated wall construction in accordance with the following requirements of 2000 NFPA 101, Section 18.3.2.1. The deficient practice could affect 15 out of 67 residents. Findings include: On facility tour between 10:45 AM and 4:45 PM on 04/30/2014, observation revealed,that the following was found: 1. Repair shop # 523 - Open penetrations on west and north walls 2. Linen storage room # 525 (over 100 sq ft.) kick stop holding door open 3. Soiled utility room # 207B - door will not shut/latch These deficient practices were confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 029	Repair shop #523 had all open penetrations sealed on 5/20/2014. Linen storage door (room #525) kick stop was removed on 5/2/2014. The door for soiled utility room #207B was repaired to shut and latch on 5/20/2014. All penetrations and doors for appropriately closing will be monitored by the facility Maintenance Director.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 054	The timeliness of this test will be kept	6/11/14

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K 054	Continued From page 4 facility failed maintain the fire alarm system in accordance with the requirement 2000 NFPA 101, Sections 18.3.4.1, 9.6.1.7 and 1999 NFPA 72, Section 7-3.2. The deficient practice could affect all 67 residents.. Findings include: On facility tour between 10:45 AM and 4:45 PM on 04/30/2014, a review of the annual fire sprinkler inspection records showed more than 12 months passed between the inspection conducted on 01-24-13 and the inspection conducted on 02-13-14. This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 054	current and monitored by the facility Maintenance Director. The logs were updated for monitoring purposes on 5/20/2014.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.5.1, 9.7.5, and 1998 NFPA 25. The deficient practice could affect all 67 residents. Findings include:	K 062	The Kitchen Cooler Sprinkler heads were cleaned on 5/14/2014. A flow and pump test was conducted on 5/6/2014. A fire sprinkler test was completed on 5/14/2014. Logs to monitor the weekly, quarterly and annual fire tests were set-up. This will be monitored by the facility maintenance director.	6/11/14

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K 062	Continued From page 5 On facility tour between 10:45 AM and 4:45 PM on 04/30/2014, the review of the following documents and obervation revealed the following: 1. The facility fire sprinkler quarterly waterflow alarm testing documentation for the past 12 months, revealed the facility failed to conduct quarterly testing for the 2nd and 4th quarters in 2013 and 1st quarter in 2014 . (1998 NFPA 25, Section 2.2.6) 2. No documentation for weekly fire pump 10 minute run test for the previous 12 months (1998 NFPA 25, Section 5-3.2) 3. No documentation for annual fire pump test for the previous 12 months (1998 NFPA 25, Section 5-3.3.1) 4. Kitchen cooler, the concealed fire sprinkler head cover has spray foam around cover. This would not allow proper activation. (1998 NFPA 25, Section 2.2.1.1) These deficient practices were confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		6/11/14

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K 144	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. This deficient practice could affect all 67 residents. Findings include: On facility tour between 10:45 AM and 4:45 PM on 04/30/2014, documentation review revealed that the following following was found: 1. Weekly Emergency Generator inspection logs from April 2013 to April 2014, did not have all the required items to be inspected on log 2. Documentation review of the monthly emergency generator testing log (May 2013 to April 2014), indicated that the facility did not run the diesel emergency generator under load at 30% of nameplate rating or by one of the following means: 1. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or 2. under load of 30 percent or more of the nameplate rating of generator or 3. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) These deficient practices were confirmed by the	K 144	Weekly and monthly generator logs were updated on 5/5/2014. A load bank test according to the manufacturer's requirements was run on 5/5/2014. This will be monitored by the facility Maintenance Director.	

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K 144	Continued From page 7 Facility Maintenance Director (KW) at the time of discovery.	K 144		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to develop a written policy containing procedures to be followed in the event the automatic fire sprinkler system is out-of-service for more than four hours in a 24-hour period in accordance with the requirements of 2000 NFPA 101, Section 9.7.6.1. This deficient practice could affect all 67 residents. Findings include: On facility tour between 10:45 AM and 4:45 PM on 04/30/2014, it was discovered during policy review and interview with the Maintenance Director (KW), that the facility has not developed a policy and procedures for an out-of-service of the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 154	An "Out of Service" policy for fire sprinklers was developed on 5/8/2014. It was placed in all manuals by 5/21/2014. This will be monitored by the facility Maintenance Director.	6/11/14
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 155		6/11/14

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K 155	Continued From page 8 Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to develop a written policy containing procedures to be followed in the event the automatic fire alarm system is out-of-service for more than four hours in a 24-hour period in accordance with the requirements of 2000 NFPA 101, Section 9.6.1.8. This deficient practice could affect all 67 residents. Findings include: On facility tour between 10:45 AM and 4:45 PM on 04/30/2014, it was discovered during policy review and interview with the Maintenance Director (KW), that the facility has not developed a policy and procedures for an out-of-service of the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 155	An "Out of Service" policy for the fire alarm system was developed on 5/8/2014 and placed in all manuals by 5/21/2014. This will be monitored by the facility Maintenance Director.	