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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D1WU

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 **07/20/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **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 :
Gary Nederhoff, Unit Supervisor 07/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
07/15/2015
(L33)

Posted 07/22/2015 Co.
DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245426

July 21, 2015

Mr. David Vandergon, Administrator
Koda Living Community
2255 30th Street Nw
Owatonna, Minnesota 55060

Dear Mr. Vandergon:

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.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 20, 2015

Mr. David Vandergon, Administrator
Koda Living Community
2255 30th Street NW
Owatonna, Minnesota 55060

RE: Project Number S5426026

Dear Mr. Vandergon:

On June 15, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 4, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 20, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 29, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 4, 2015, effective June 23, 2015 and therefore remedies outlined in our letter to you dated June 15, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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 **02 - KODA LIVING COMMUNITY**	6/29/2015

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 **06/22/2015**	ID Prefix	Correction Completed **06/22/2015**	ID Prefix	Correction Completed **06/22/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0025		LSC K0050	
ID Prefix	Correction Completed **06/22/2015**	ID Prefix	Correction Completed **06/22/2015**	ID Prefix	Correction Completed **06/22/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0062		LSC K0076		LSC K0144	
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	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	**Reviewed By** PS/kfd	**Date:** 07/20/2015	**Signature of Surveyor:** 31242	**Date:** 06/29/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/3/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245426	A. Building B. Wing	7/20/2015

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/22/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/22/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **06/22/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **06/23/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	07/20/2015	10160	07/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/4/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D1WU

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 **06/04/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **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

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

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 :
Lisa Carey (Krebs), HFE NE II 06/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/15/2015 (L20)

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

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

Posted 07/15/2015 Co.

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 15, 2015

Mr. David Vandergon, Administrator
Koda Living Community
2255 30th Street NW
Owatonna, Minnesota 55060

RE: Project Number S5426026

Dear Mr. Vandergon:

On June 4, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
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 July 14, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 14, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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 _____	06/04/2015

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 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 ensure catheter care was provided according to the care plan for 1 of 1 resident (R67) reviewed for urinary catheter use. Findings include: R67's face sheet, dated 6/4/15 revealed active diagnoses of neurogenic bladder, altered mental status and urinary tract infection. R67's admission minimum data set (MDS), dated 3/31/15 revealed R67 had an indwelling urinary	F 282	Resident 67 is identified as needing to have frequent monitoring of catheter care. Frequency will be varied according to the needs of the patient. Care plan was changed to accommodate the needs of the patient. Current residents with indwelling catheters care plans also have been reviewed and updated as necessary. Any new admissions with indwelling catheters will be evaluated and care plans will be established based on the needs of the	6/22/15

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

Electronically Signed | 06/23/2015

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 _____	06/04/2015

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 282	Continued From page 1 catheter. R67's brief interview for mental status score (BIMS) was 12 (moderate cognitive impairment). R67's June 2015 medication administration record revealed R67 had started taking Levaquin (a broad-spectrum antibiotic) on 5/29/15 for a urinary tract infection. R67's care area assessment (CAA) related to urinary continence, dated 4/1/15 indicated R67 was continent with an indwelling catheter. A cognitive loss/dementia CAA, dated 4/3/15 indicated R67 had short term memory problems. R67's care plan, dated 6/3/15 indicated R67 had a indwelling catheter and the bag was to be checked every two hours and emptied as needed, with output to be documented in the electronic medical record. The care plan further stated R67 was to wear a leg bag during the day and a drain bag at night. During observation on 6/1/15, at 6:21 p.m. R67's room had a strong urine odor present which was most prominent in the bathroom. R67 was seated in his wheelchair and his indwelling catheter bag was secured to his lower leg with elastic straps. During observation on 6/3/15, at 7:31 a.m. R67 was seated in his wheelchair in his room. His catheter was connected to a large volume drainage bag which was unsecured to his leg, and R67 was holding it on his lap even though R67's care plan said the leg bag was to be used during the day. The catheter bag contained a small amount of amber covered urine in the tubing and the bag was covered with a blue vinyl	F 282	resident. Education for all nursing staff will be provided on June 30th, 2015 on the importance of care plans reflecting the needs of the resident, and the policy review of Closed System Urinary Care. Care Plans of residents with indwelling catheters will be audited for current assessment and accuracy per MDS schedule. DON/designee will report audit results to Quality Review Committee	

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F 282	Continued From page 2	F 282		

bag. R67 indicated that he had emptied his own bag of urine this morning at 5:00 a.m., stating, "I had to do it myself, no one came." R67 proceeded to pick the bag up and look at the contents, holding it at eye level. R67 denied any bladder discomfort. Again there was a strong urine odor present in R67's bathroom.

During observation on 6/3/15, at 7:35 a.m. R67 was noted to be wheeling himself to the dining area with the catheter bag on his lap, above bladder level. R67 proceeded to breakfast where he remained until 9:00 a.m.

During observation on 6/3/15, at 9:00 a.m. R67 went to his room and entered his bathroom. R67 came back out of the bathroom, holding his catheter bag in one hand near eye level stating, "There's about 200 [cubic centimeters] in there now." R67 stated no one had helped him yet today to empty the catheter bag. Licensed practical nurse (LPN)-A entered R67's room and helped him into his recliner. At 9:13 a.m., an activities staff (unidentified) took R67 to morning exercise and hooked his catheter drainage bag to the lower side of his wheelchair, covering it with a blue vinyl bag.

During observation on 6/3/15, at 1:05 p.m. R67 indicated he had not had assistance to empty his catheter bag this shift. Approximately 250 cubic centimeters (cc's) were observed in the bag at this time. The urine was a dark straw color. A strong urine odor was present about R67 and his bathroom. R67 was unable to state why he was wearing the large drainage bed rather than the smaller leg bag he had on the previous day.

During observation on 6/4/15, at 9:15 a.m. R67

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F 282	Continued From page 3	F 282		

was observed at the dining room table with a large drainage bag connected to his catheter, which was covered in a blue vinyl bag.

During interview on 6/4/15, at 9:12 a.m. nursing assistant (NA)-A stated R67 needed to be checked on every hour or so as he tried to care for his own catheter. NA-A indicated R67's leg bag had been taken away from him on 6/2/15 as he had been emptying it on his own. NA-A stated each time the catheter was emptied by staff it was documented in the electronic medical record.

During interview on 6/4/15, at 1:02 p.m. LPN-A indicated the NA staff should be checking on R67 every two hours at a minimum to monitor his catheter, as he tried to empty it per himself and often spilled urine, was significantly cognitively impaired and had a recent bladder infection. LPN-A pulled up on the computer R67's urine output report charting completed by the NA staff for the date of 6/3/15 and confirmed R67's catheter had not been emptied as directed by the care plan and that there was no recording of this being completed at all on the day shift, and only one output recorded for the 24 hour period at 10:00 p.m. LPN-A stated all residents had been switched to the large drainage bags effective 6/2/15 per the new director of nursing (DON) and this had been passed along to staff in their communication book.

The facility policy entitled Catheter Care, Urinary, last revised 10/10 indicated the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. the policy further indicated the resident should be checked on frequently to

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F 282	Continued From page 4 be sure he or she is not lying on the catheter, to keep the catheter and tubing free of kinks and indicated the collection bag should be emptied at least every eight hours.	F 282		
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 record review, the facility failed to identify, monitor, and treat a skin lesion for 1 of 3 (R83) residents reviewed for non-pressure related skin concerns. Findings include: During an observation on 6/2/15, at 10:20 a.m. R83 was noted to have an abrasion on right cheek that measured approximately 1 centimeter (cm) in length by 0.2 cm in width. The abrasion was covered by three superficial scabs. R83 explained he had picked a pimple over the summer time and they became the scabs. R83 further stated sometimes the area itched. R83 also had a pea sized gray spot on left temple area that was slightly raised however intact. R83's medical record did not identify how long the abrasion on the right cheek or the discolored skin area on the left temple had been there. R83 was admitted to the facility on 3/17/15 according to the facility admission record.	F 309	On 6/3/15 resident 83 was examined by facilities Nurse Practioner. Resident is no longer living at our location. All residents skin checks are completed weekly and reviewed by the licensed nursing staff and care plans revised accordingly DON reviewed and revised policy on the weekly skin checks. Education will be provided by DON to all nursing staff on the updated policy on June 30th, 2015 5% of resident skin checks will be audited weekly times 4 weeks. Following initial review, audit reviews will be adjust accordingly.	6/22/15

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F 309	Continued From page 5 Routine physician visit progress note dated 4/9/15 included but was not limited to diagnoses of dementia, glaucoma, and history of basal cell skin cancer of the right ear (was excised in 1989). R83's quarterly Minimum Data Set (MDS) dated 3/12/15 indicated staffed assessed moderately impaired cognition with memory problem, required supervision with one staff physical assist for hygiene, and the MDS indicated no wounds or lesions were present at the time of the assessment. R83's care plan provided by the facility on 6/2/15 did not identify abrasion on right cheek or gray colored skin area on left temple region. The care plan failed to identify skin care surveillance, interventions to maintain and monitor general skin integrity, and did not identify history of skin cancer. The care plan gave direction to apply Vanicream to dry skin all over and care of perineal area. R83's routine physician visit progress note dated 4/9/15 did not mention the impaired skin integrity areas. The progress note read, "Skin: warm and dry without rashes on the visible areas." R83's routine physician visit progress note dated 2/12/15 read, "Skin: He does have fairly dry flaky skin on arms and legs. No other specific rashes. He does have a little what appears to be a scrape on his right cheek that is clean." Because R83's medical record in that time period did not identify the "scrape" on R83's face, it cannot be determined if the scrape mentioned on 2/12/15 healed or if it's the same abrasion that was observed on 6/2/15 that has not healed. R83's nursing progress notes and skin assessments were reviewed from 2/1/15 through 6/2/15; documentation did not reflect identification, monitoring, or treatment of any skin abrasions, lesions, or discolorations on R83's	F 309		

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F 309	Continued From page 6 face. R83's CNA (certified nursing assistant) Bath Sheets dated 2/6/15, 2/20/15, 3/27/15, 4/2/15, and 4/17/15 did not identify the right cheek abrasion or discolored skin area on left temple. The facility was not able to provide CNA Bath Sheets for dates between 2/6/15 and 2/20/15, from 2/20/15 through 3/27/15, and from 4/2/15 through 4/17/15. The facility also was not able to provide CNA bath sheets after 4/17/15. During an interview on 6/3/15, at 8:02 a.m., registered nurse (RN)-B explained skin observations were supposed to be done weekly by the CNAs with the residents' bath, CNAs recorded their findings on bath sheets and returned to the nurse, the nurse then would follow up with any noted concerns, the wound nurse would then follow up. RN-B stated had not been aware of either impaired skin integrity areas on R83. During an interview on 6/3/15, at 8:27 a.m., RN-C wound nurse verified the abrasion on R83's right cheek and the gray discoloration on left temple. RN-C stated, "That should be checked out to rule out carcinoma." RN-C stated she had not been notified of the areas of impaired skin integrity. RN-C stated the expectation was she should have been notified with any skin problems. During an interview on 6/3/15, at 9:30 a.m., interim director of nursing (DON) stated she expected the licensed nurse to inspect skin on a weekly basis on the resident's bath day and as needed. Interim DON further stated, changes to skin integrity were to be documented, the physician and family member notified, and necessary monitoring, interventions, and any treatments put into place and care planned. Interim DON also verified the care plan lacked a skin focus area.	F 309		

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F 309	Continued From page 7 Facility policies/procedures that were obtained lacked direction on identification of and/or surveillance for impaired skin integrity, reporting to designated staff members for follow-up and care, monitoring modalities, documentation, and care plan consideration and decision making.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure catheter care was provided according to the care plan for 1 of 1 resident (R67) reviewed for urinary catheter use. Findings include: R67 lacked the use of the leg bag for urine drainage as directed on R67's care plan, also staff did not empty bag at least every two hours and record output consistently. R67's face sheet, dated 6/4/15 revealed active diagnoses of neurogenic bladder, altered mental status and urinary tract infection.	F 315	Resident 67 is identified as needing to have frequent monitoring of catheter care. Frequency will be varied according to the needs of the patient. Care plan was changed to accommodate the needs of the patient. Current residents with indwelling catheters care plans also have been reviewed and updated as necessary. Any new admissions with indwelling catheters will be evaluated and care plans will be established based on the needs of the resident.	6/22/15

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F 315	Continued From page 8 R67's admission minimum data set (MDS), dated 3/31/15 revealed R67 had an indwelling urinary catheter. R67's brief interview for mental status score (BIMS) was 12 (moderate cognitive impairment). R67's 6/15 medication administration record revealed R67 had started taking Levaquin (a broad-spectrum antibiotic) on 5/29/15 for a urinary tract infection. R67's care area assessment (CAA) related to urinary continence, dated 4/1/15 indicated R67 was continent with an indwelling catheter. A cognitive loss/dementia CAA, dated 4/3/15 indicated R67 had short term memory problems. R67's care plan, dated 6/3/15 indicated R67 had a indwelling catheter and the bag was to be checked every two hours and emptied as needed, with output to be documented in the electronic medical record. The care plan further stated R67 was to wear a leg bag during the day and a drain bag at night. During observation on 6/1/15, at 6:21 p.m. R67's room had a strong urine odor present which was most prominent in the bathroom. R67 was seated in his wheelchair and his indwelling catheter bag was secured to his lower leg with elastic straps. During observation on 6/3/15, at 7:31 a.m. R67 was seated in his wheelchair in his room. His catheter was connected to a large volume drainage bag which was unsecured to his leg, and R67 was holding it on his lap. The catheter bag contained a small amount of amber covered urine in the tubing and the bag was covered with	F 315	Education for all nursing staff will be provided on June 30th, 2015 on the importance of care plans reflecting the needs of the resident, and the policy review of Closed System Urinary Care. Care Plans of residents with indwelling catheters will be audited for current assessment and accuracy per MDS schedule. DON/designee will report audit results to Quality Review Committee	

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F 315	Continued From page 9	F 315		

a blue vinyl bag. R67 indicated that he had emptied his own bag of urine this morning at 5:00 a.m., stating "I had to do it myself, no one came." R67 proceeded to pick the bag up and look at the contents, holding it at eye level. R67 denied any bladder discomfort. A strong urine odor was present in R67's bathroom.

During observation on 6/3/15, at 7:35 a.m. R67 was noted to be wheeling himself to the dining area with the catheter bag on his lap, above bladder level. R67 proceeded to breakfast where he remained until 9:00 a.m.

During observation on 6/3/15, at 9:00 a.m. R67 went to his room and entered his bathroom. R67 came back out of the bathroom, holding his catheter bag in one hand near eye level stating "There's about 200 [cubic centimeters] in there now." R67 stated non one had helped him yet today to empty the catheter bag. LPN-A entered R67's room and helped him into his recliner. At 9:13 a.m., an activities staff (unidentified) took R67 to morning exercise and hooked his catheter drainage bag to the lower side of his wheelchair, covering it with a blue vinyl bag.

During observation on 6/3/15, at 1:05 p.m. R67 indicated he still had not had assistance to empty his catheter bag this shift. Approximately 250 cubic centimeters (cc's) were observed in the bag at this time. The urine was a dark straw color. A strong urine odor was present about R67 and the bathroom. R67 was unable to state why he was wearing the large drainage bed rather that the smaller leg bag he had on the previous day.

During observation on 6/4/15, at 9:15 a.m. R67 was observed at the dining room table with a

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F 315	Continued From page 10	F 315		

large drainage bag connected to his catheter, which was covered in a blue vinyl bag.

During interview on 6/4/15, at 9:12 a.m. nursing assistant (NA)-A stated R67 needed to be checked on every hour or so and emptied as he tried to care for his own catheter. NA-A indicated R67's leg bag had been taken away from him on 6/2/15 as he had been emptying it on his own. NA-A stated each time the catheter was emptied by staff it was documented in the electronic medical record.

During interview on 6/4/15, at 1:02 p.m. LPN-A indicated the NA staff should be checking on R67 every two hours at a minimum to monitor his catheter, as he tried to empty it per himself and often spilled urine, was significantly cognitively impaired and had a recent bladder infection. LPN-A pulled up R67's urine output report charting completed by the NA staff for the date of 6/3/15 and confirmed R67's catheter had not been emptied as directed by the care plan and that there was no recording of this being completed at all on the day shift, and only one output recorded for the 24 hour period at 10:00 p.m. LPN-A stated all residents had been switched to the large drainage bags effective 6/2/15 per the new director of nursing (DON) and this had been passed along to staff in their communication book.

The facility policy entitled Catheter Care, Urinary, last revised 10/10 indicated the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. the policy further indicated the resident should be checked on frequently to

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F 315	Continued From page 11 be sure he or she is not lying on the catheter, to keep the catheter and tubing free of kinks and indicated the collection bag should be emptied at least every eight hours.	F 315		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the exhaust vents were cleaned to maintain a sanitary bathroom environment in 18 out of 35 bathrooms used by residents who reside in rooms 104, 105, 106, 107, 108, 118, 217, 303, 307, 311, 321, 315, 402, 404, 406, 416, 417, and 419. Findings Include: Upon entrance to the facility on 6/1/15 resident bathrooms in rooms 105, 106, 108, 217, 404, and 406 were observed to have visible heavy dust present on the vent grille cover. Upon further investigation on 6/4/15 revealed 18 out of 35 resident bathrooms in rooms 104, 105, 106, 107, 108, 118, 217, 303, 307, 311, 321, 315, 402, 404, 406, 416, 417, and 419 to have heavy surface dust on vent grille covers, visible from the doorway of the bathroom. On 6/4/15 at 10:24 a.m. the maintenance lead was asked about cleaning air vents, he stated,	F 465	Ceiling vents were cleaned immediately upon being informed of the issue. To ensure this is not an issue in the future, a schedule has been set up to clean all vents on a monthly basis and as needed. One neighborhood a month will be audited by the Maintenance Lead.	6/23/15

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F 465	Continued From page 12 "The fresh air exit vents are cleaned as needed, I know they need them." The maintenance lead then walked with surveyor to the Dawn unit, room 406 bathroom where he stated, "They [bathroom vents] shouldn't get that bad. Housekeeping policy is to check and clean as needed. We have been short handed and housekeeping is suppose to do the bathroom vents." The maintenance lead verified the vent grille cover totally covered with thick layer of dust. House Keeping Practices, undated; Terminal/deep cleaning rooms: "6. Clean and Wipe all furniture items, (i.e. bedside tables, over bed tables, wardrobes, chairs, blinds, vents, and bed.)" Monthly Cleaning Schedule, undated; "D-vents; 1. clean all vents in bathroom when needed."	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**06/03/2015**

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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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 | 06/22/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**06/03/2015**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire	K 011		6/22/15

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K 011	Continued From page 2 barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 18.1.1.4, 18.1.2.3 and 8.2.3.2. The deficient practice could affect 30 out of 62 residents. Findings include: On facility tour between 8:00 AM and 12:00 noon on 06/03/2015, observation revealed, the 2 hour fire separation wall between Koda Living Community and Hospital, has open penetration above the lay in ceiling. This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 011	The 2 hour fire separation wall between Koda and Hospital, has open penetration above the lay in ceiling. Although the side that was not caulked was on the hospital side of the wall, we have caulked all penetrations on both sides of the wall with fire-caulk on 6-3-2015. We also check the other fire walls to insure that all penetrations are caulked as required.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted	K 025		6/22/15

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K 025	Continued From page 3 heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 18.3.7.3, and 8.3.4.1. The deficient practice could affect 15 out of 62 residents. Findings include: On facility tour between 8:00 AM and 12:00 noon on 06/03/2015, observation revealed that the smoke barrier wall for the Kindle Wing - has open penetration above lay in ceiling. NOTE: Ensure ALL smoke barrier walls from exterior wall to exterior wall are checked for this deficiency. This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 025	K25 The smoke wall for Kindle Wing ¿ has open penetration above lay in ceiling. Checked all smoke walls within the building and repaired all found penetrations. All have been caulked with fire-caulk as of 6-4-2015.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		6/22/15

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K 050	Continued From page 4 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 62 residents. Findings include: On facility tour between 8:00 AM and 12:00 noon on 06/03/2015, the review of the fire drills reports for June 2014 to May 2015 and the following was found: 1. 2014 - 4th quarter night shift drill was missed 2. The fire drills did not sufficiently vary the times that the drills were conducted on the night shift: 2200, 2200 and 2200 hours These deficient practices were confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 050	K50 Review of the past 12 months of fire drills and the following was found: 1. 2014 ¿ 4th quarter night shift drills were missed The fire drills for fourth quarter, night shift where inadvertently scheduled for the wrong times thereby causing them to be done on the wrong shifts. Every effort will be made to insure that this will not happen again. Plus Custom Alarm has agreed to send us a report via email after each drill. 2. The fire drills did not sufficiently vary the times that the drills were conducted on the night shift: 2200, 2200, and 2200 hours All fire drills on all shifts will be scheduled at least two hours from the previous drills time. Every effort will be made to comply with this requirement from now on.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		6/22/15

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K 062	Continued From page 5 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 62 residents. Findings include: On facility tour between 8:00 AM and 12:00 noon on 06/03/2015, the review of the annual sprinkler and fire pump inspection/test was not done in the last 12 months. Last documented inspection/test was on 5/6/2014 from Brothers Fire Protection. These deficient practices were confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 062	K62 The review of the annual sprinkler and fire pump inspection test was not done in the last 12 months. Last documented on 5/6/2014 from Brothers Fire Protection. Annual sprinkler and fire pump inspection and test was successfully conducted today 6-15-15, no problems were found. Brother Fire Protection will do this inspection and test on 6-15-2015, and it will be done on or before this date each year from now on to insure it is done well within the 365 days required. Coordination has already been made between Brother and Koda to insure that this is done correctly and on time.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than	K 076		6/22/15

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K 076	Continued From page 6 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure oxygen room install electrical as required by 1999 NFPA 99 -4-3.1.1.2 (4). The deficient practice could affect 20 out of 62 residents. Findings include: On facility tour between 8:00 AM and 12:00 noon on 06/03/2015, observation revealed, the oxygen storage room over 3000 cubic feet, has an electric outlet and light switch mount less than 5 feet above the floor. This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 076	K76 Oxygen storage room over 3000 cubic feet, has electric outlet and light switch mount less than 5 feet above the floor. R & K Electric was scheduled to move both the outlet and switch above the 5 foot level as required. Move completed 6-5-15	
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. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test the emergency generator in	K 144	K144 Review of the emergency generator weekly inspection and monthly	6/22/15

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K 144	Continued From page 7 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 62 residents. Findings include: On facility tour between 8:00 AM and 12:00 noon on 06/03/2015, documentation review of the emergency generator weekly inspection and monthly run test the following was found 1. Weekly inspections for 12/1/2014 and 4/27/2015 were not documented 2. The annual load bank test was not completed with-in 12 months. 05/05/2014 and 05/29/15 These deficient practices were confirmed by the Facility Maintenance Director (KW) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	run test the following was found: 1. Weekly inspections for 12/1/2014 and 4/27/2015 were not documented. a. The 12-1-14 weekly inspection was done on time on 12-6-14 but not logged into the Tels computer system until 12-8-14. We couldn¿t find the documentation while Inspector was here. b. The 4-27-15 weekly inspection was done on time on 4-30-15, but not logged into Tels until 5-4-15. We couldn¿t find the documentation while the Inspector was here. Greater effort will be made to log these inspections into the computer the same day they are done each week. 2. The annual load bank test was not completed with-in 12 months. 05/05/2014 and 05/29/15 On 4-19-15 Interstate Power came and did the annual maintenance check to be followed up with the Load test on 5-4-15. Interstate Power then called and said that two of their three sleds were done and that they would get to us just as soon as they could, and that was 5-29-15, not within the 365 days as required. I talked to Interstate Power and told them of our requirement to get this test done on time. We have scheduled next year¿s test for the second week of May, well within the 365 days as required. Every effort will be made to see that we comply with the required time frame from now on.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
June 15, 2015

Mr. David Vandergon, Administrator
Koda Living Community
2255 30th Street NW
Owatonna, Minnesota 55060

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5426026

Dear Mr. Vandergon:

The above facility was surveyed on June 1, 2015 through June 4, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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
	00644	A. BUILDING: _____ B. WING _____	06/04/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 1, 2, 3, and 4, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure catheter care was provided according to the care plan for 1 of 1 resident (R67) reviewed for urinary catheter use. Findings include: R67's face sheet, dated 6/4/15 revealed active diagnoses of neurogenic bladder, altered mental status and urinary tract infection. R67's admission minimum data set (MDS), dated 3/31/15 revealed R67 had an indwelling urinary catheter. R67's brief interview for mental status score (BIMS) was 12 (moderate cognitive impairment). R67's June 2015 medication administration record revealed R67 had started taking Levaquin (a broad-spectrum antibiotic) on 5/29/15 for a urinary tract infection.	2 565	Resident 67 is identified as needing to have frequent monitoring of catheter care. Frequency will be varied according to the needs of the patient. Care plan was changed to accommodate the needs of the patient. Current residents with indwelling catheters care plans also have been reviewed and updated as necessary. Any new admissions with indwelling catheters will be evaluated and care plans will be established based on the needs of the resident. Education for all nursing staff will be provided on June 30th, 2015 on the importance of care plans reflecting the needs of the resident, and the policy review of Closed System Urinary Care. Care Plans of residents with indwelling	6/22/15

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2 565	Continued From page 3 R67's care area assessment (CAA) related to urinary continence, dated 4/1/15 indicated R67 was continent with an indwelling catheter. A cognitive loss/dementia CAA, dated 4/3/15 indicated R67 had short term memory problems. R67's care plan, dated 6/3/15 indicated R67 had a indwelling catheter and the bag was to be checked every two hours and emptied as needed, with output to be documented in the electronic medical record. The care plan further stated R67 was to wear a leg bag during the day and a drain bag at night. During observation on 6/1/15, at 6:21 p.m. R67's room had a strong urine odor present which was most prominent in the bathroom. R67 was seated in his wheelchair and his indwelling catheter bag was secured to his lower leg with elastic straps. During observation on 6/3/15, at 7:31 a.m. R67 was seated in his wheelchair in his room. His catheter was connected to a large volume drainage bag which was unsecured to his leg, and R67 was holding it on his lap even though R67's care plan said the leg bag was to be used during the day. The catheter bag contained a small amount of amber covered urine in the tubing and the bag was covered with a blue vinyl bag. R67 indicated that he had emptied his own bag of urine this morning at 5:00 a.m., stating, "I had to do it myself, no one came." R67 proceeded to pick the bag up and look at the contents, holding it at eye level. R67 denied any bladder discomfort. Again there was a strong urine odor present in R67's bathroom. During observation on 6/3/15, at 7:35 a.m. R67 was noted to be wheeling himself to the dining	2 565	catheters will be audited for current assessment and accuracy per MDS schedule. DON/designee will report audit results to Quality Review Committee	

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2 565	Continued From page 4	2 565		

area with the catheter bag on his lap, above bladder level. R67 proceeded to breakfast where he remained until 9:00 a.m.

During observation on 6/3/15, at 9:00 a.m. R67 went to his room and entered his bathroom. R67 came back out of the bathroom, holding his catheter bag in one hand near eye level stating, "There's about 200 [cubic centimeters] in there now." R67 stated no one had helped him yet today to empty the catheter bag. Licensed practical nurse (LPN)-A entered R67's room and helped him into his recliner. At 9:13 a.m., an activities staff (unidentified) took R67 to morning exercise and hooked his catheter drainage bag to the lower side of his wheelchair, covering it with a blue vinyl bag.

During observation on 6/3/15, at 1:05 p.m. R67 indicated he had not had assistance to empty his catheter bag this shift. Approximately 250 cubic centimeters (cc's) were observed in the bag at this time. The urine was a dark straw color. A strong urine odor was present about R67 and his bathroom. R67 was unable to state why he was wearing the large drainage bed rather than the smaller leg bag he had on the previous day.

During observation on 6/4/15, at 9:15 a.m. R67 was observed at the dining room table with a large drainage bag connected to his catheter, which was covered in a blue vinyl bag.

During interview on 6/4/15, at 9:12 a.m. nursing assistant (NA)-A stated R67 needed to be checked on every hour or so as he tried to care for his own catheter. NA-A indicated R67's leg bag had been taken away from him on 6/2/15 as he had been emptying it on his own. NA-A stated each time the catheter was emptied by staff it

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2 565	Continued From page 5 was documented in the electronic medical record. During interview on 6/4/15, at 1:02 p.m. LPN-A indicated the NA staff should be checking on R67 every two hours at a minimum to monitor his catheter, as he tried to empty it per himself and often spilled urine, was significantly cognitively impaired and had a recent bladder infection. LPN-A pulled up on the computer R67's urine output report charting completed by the NA staff for the date of 6/3/15 and confirmed R67's catheter had not been emptied as directed by the care plan and that there was no recording of this being completed at all on the day shift, and only one output recorded for the 24 hour period at 10:00 p.m. LPN-A stated all residents had been switched to the large drainage bags effective 6/2/15 per the new director of nursing (DON) and this had been passed along to staff in their communication book. The facility policy entitled Catheter Care, Urinary, last revised 10/10 indicated the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. the policy further indicated the resident should be checked on frequently to be sure he or she is not lying on the catheter, to keep the catheter and tubing free of kinks and indicated the collection bag should be emptied at least every eight hours. SUGGESTED PLAN OF CORRECTION: The DON could review the care plan for appropriateness of interventions and care and develop and implement audits to ensure the care plan is being followed. TIME PERIOD FOR CORRECTION: Twenty one	2 565		

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2 565	Continued From page 6 (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify, monitor, and treat a skin lesion for 1 of 3 (R83) residents reviewed for non-pressure related skin concerns. Findings include: During an observation on 6/2/15, at 10:20 a.m. R83 was noted to have an abrasion on right cheek that measured approximately 1 centimeter (cm) in length by 0.2 cm in width. The abrasion was covered by three superficial scabs. R83 explained he had picked a pimple over the summer time and they became the scabs. R83 further stated sometimes the area itched. R83 also had a pea sized gray spot on left temple area that was slightly raised however intact. R83's medical record did not identify how long the abrasion on the right cheek or the discolored skin	2 830	On 6/3/15 resident 83 was examined by facilities Nurse Practioner. Resident is no longer living at our location. All residents skin checks are completed weekly and reviewed by the licensed nursing staff and care plans revised accordingly DON reviewed and revised policy on the weekly skin checks. Education will be provided by DON to all nursing staff on the updated policy on June 30th, 2015 5% of resident skin checks will be audited weekly times 4 weeks. Following initial review, audit reviews will be adjust accordingly.	6/22/15

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2 830	Continued From page 7	2 830		

area on the left temple had been there.
R83 was admitted to the facility on 3/17/15 according to the facility admission record.
Routine physician visit progress note dated 4/9/15 included but was not limited to diagnoses of dementia, glaucoma, and history of basal cell skin cancer of the right ear (was excised in 1989).
R83's quarterly Minimum Data Set (MDS) dated 3/12/15 indicated staffed assessed moderately impaired cognition with memory problem, required supervision with one staff physical assist for hygiene, and the MDS indicated no wounds or lesions were present at the time of the assessment.
R83's care plan provided by the facility on 6/2/15 did not identify abrasion on right cheek or gray colored skin area on left temple region. The care plan failed to identify skin care surveillance, interventions to maintain and monitor general skin integrity, and did not identify history of skin cancer. The care plan gave direction to apply Vanicream to dry skin all over and care of perineal area.
R83's routine physician visit progress note dated 4/9/15 did not mention the impaired skin integrity areas. The progress note read, "Skin: warm and dry without rashes on the visible areas."
R83's routine physician visit progress note dated 2/12/15 read, "Skin: He does have fairly dry flaky skin on arms and legs. No other specific rashes. He does have a little what appears to be a scrape on his right cheek that is clean." Because R83's medical record in that time period did not identify the "scrape" on R83's face, it cannot be determined if the scrape mentioned on 2/12/15 healed or if it's the same abrasion that was observed on 6/2/15 that has not healed.
R83's nursing progress notes and skin assessments were reviewed from 2/1/15 through 6/2/15; documentation did not reflect

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2 830	Continued From page 8	2 830		

identification, monitoring, or treatment of any skin abrasions, lesions, or discolorations on R83's face.
R83's CNA (certified nursing assistant) Bath Sheets dated 2/6/15, 2/20/15, 3/27/15, 4/2/15, and 4/17/15 did not identify the right cheek abrasion or discolored skin area on left temple. The facility was not able to provide CNA Bath Sheets for dates between 2/6/15 and 2/20/15, from 2/20/15 through 3/27/15, and from 4/2/15 through 4/17/15. The facility also was not able to provide CNA bath sheets after 4/17/15.
During an interview on 6/3/15, at 8:02 a.m., registered nurse (RN)-B explained skin observations were supposed to be done weekly by the CNAs with the residents' bath, CNAs recorded their findings on bath sheets and returned to the nurse, the nurse then would follow up with any noted concerns, the wound nurse would then follow up. RN-B stated had not been aware of either impaired skin integrity areas on R83.
During an interview on 6/3/15, at 8:27 a.m., RN-C wound nurse verified the abrasion on R83's right cheek and the gray discoloration on left temple. RN-C stated, "That should be checked out to rule out carcinoma." RN-C stated she had not been notified of the areas of impaired skin integrity. RN-C stated the expectation was she should have been notified with any skin problems.
During an interview on 6/3/15, at 9:30 a.m., interim director of nursing (DON) stated she expected the licensed nurse to inspect skin on a weekly basis on the resident's bath day and as needed. Interim DON further stated, changes to skin integrity were to be documented, the physician and family member notified, and necessary monitoring, interventions, and any treatments put into place and care planned. Interim DON also verified the care plan lacked a

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2 830	Continued From page 9 skin focus area. Facility policies/procedures that were obtained lacked direction on identification of and/or surveillance for impaired skin integrity, reporting to designated staff members for follow-up and care, monitoring modalities, documentation, and care plan consideration and decision making. SUGGESTED PLAN OF CORRECTION: The DON could review and update policies pertaining to skin surveillance, provide education on monitoring and reporting, and develop and implement an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		6/22/15

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21426	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 employees (E-1 and E2) newly hired were screened for tuberculosis (TB) as required. Findings include: E1 was rehired on 3/10/15. However, there was no evidence a current baseline TB symptom screen had been done nor the two step tuberculin skin test (TST) since rehire on 3/10/15. E1 file did contain TST information from June/July 2014 but had left employment for a period of time. E2 was hired on 3/18/15. Review of E2's employee file indicated a baseline TB symptom screen and 1st step TST dated 3/18/15. The file did not include evidence a second step TST had been completed. When interviewed on 6/3/15, at 11:41 a.m. the infection control registered nurse (RN)- confirmed E1's employee record did not include evidence that a baseline TB screen nor 2-step TST had been completed since rehire on 3/10/15. RN- further confirmed that E2 did not receive a second step TST. The policy titled, "Tuberculosis, Employee Screening for", revised 4/12/14, included: "All employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and	21426	TB testing has been added to the new employee checklist. Training has been provided to all staff envolved in the new hire process. Audits will be completed on 5% of all new staff to ensure following of new procedure.	

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21426	Continued From page 11 symptom screening, prior to beginning employment. The need for annual testing shall be determined by the annual TB risk classification or as per State regulations." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could reeducate nursing staff to their policies for resident and employee Tuberculosis screening, and could perform audits to ensure their policies were being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the exhaust vents were cleaned to maintain a sanitary bathroom environment in 18 out of 35 bathrooms used by residents who reside in rooms 104, 105, 106, 107, 108, 118, 217, 303, 307, 311, 321, 315, 402, 404, 406, 416, 417, and 419. Findings Include: Upon entrance to the facility on 6/1/15 resident	21695	Ceiling vents were cleaned immediately upon being informed of the issue. To ensure this is not an issue in the future, a schedule has been set up to clean all vents on a monthly basis and as needed. One neighborhood a month will be audited by the Maintenance Lead.	6/23/15

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21695	Continued From page 12 bathrooms in rooms 105, 106, 108, 217, 404, and 406 were observed to have visible heavy dust present on the vent grille cover. Upon further investigation on 6/4/15 revealed 18 out of 35 resident bathrooms in rooms 104, 105, 106, 107, 108, 118, 217, 303, 307, 311, 321, 315, 402, 404, 406, 416, 417, and 419 to have heavy surface dust on vent grille covers, visible from the doorway of the bathroom. On 6/4/15 at 10:24 a.m. the maintenance lead was asked about cleaning air vents, he stated, "The fresh air exit vents are cleaned as needed, I know they need them." The maintenance lead then walked with surveyor to the Dawn unit, room 406 bathroom where he stated, "They [bathroom vents] shouldn't get that bad. Housekeeping policy is to check and clean as needed. We have been short handed and housekeeping is suppose to do the bathroom vents." The maintenance lead verified the vent grille cover totally covered with thick layer of dust. House Keeping Practices, undated; Terminal/deep cleaning rooms: "6. Clean and Wipe all furniture items, (i.e. bedside tables, over bed tables, wardrobes, chairs, blinds, vents, and bed.)" Monthly Cleaning Schedule, undated; "D-vents; 1. clean all vents in bathroom when needed." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible.	21695		

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21695	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		