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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L3UF

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 **11/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **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:

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

* Code: **A*** (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 : Brenda Fischer, Unit Supervisor 12/6/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 12/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **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 11/21/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245426

December 6, 2016

Mr. David Vandergon, Administrator
Koda Living Community
2255 30th Street NW
Owatonna, MN 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 November 15, 2016 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

December 6, 2016

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

RE: Project Number Project Number S5426028

Dear Mr. Vandergon:

On October 24, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 6, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on 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 October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 6, 2016, effective November 15, 2016 and therefore remedies outlined in our letter to you dated October 24, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245426 Y1	A. Building B. Wing Y2	11/28/2016 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0280	Correction	ID Prefix	F0281	Correction
Reg. #	483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(i)	Completed
LSC		11/15/2016	LSC		11/15/2016	LSC		11/15/2016
ID Prefix	F0282	Correction	ID Prefix	F0309	Correction	ID Prefix	F0314	Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	Completed	Reg. #	483.25(c)	Completed
LSC		11/15/2016	LSC		11/15/2016	LSC		11/15/2016
ID Prefix	F0329	Correction	ID Prefix	F0441	Correction	ID Prefix		Correction
Reg. #	483.25(l)	Completed	Reg. #	483.65	Completed	Reg. #		Completed
LSC		11/15/2016	LSC		11/15/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/kfd	12/6/2016	10562	11/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/6/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245426 Y1	A. Building 02 - KODA LIVING COMMUNITY B. Wing Y2	11/15/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	11/15/2016	LSC K0018	11/15/2016	LSC K0046	11/15/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0062	11/15/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	12/06/2016	37008	11/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/5/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L3UF

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 **10/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **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
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Sarah Strenke, HFE NE II 11/9/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/18/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **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 11/21/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 24, 2016

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

RE: Project Number S5426028 and Complaint Number H5426025

Dear Mr. Vandergon:

On October 6, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 6, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: 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 November 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 6, 2017 (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 April 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	10/06/2016

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. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaint H5426025 was completed and found not to be substantiated.	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is	F 156		11/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/02/2016

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 _____	10/06/2016

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 156	Continued From page 1 entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone	F 156		

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 _____	10/06/2016

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 156	Continued From page 2 numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of all Medicare Part A skilled services for 4 of 4 residents (R12, R2, R9 and R24) reviewed for liability notice and beneficiary appeal rights. Findings include: R12 was discharged from Medicare Part A on	F 156	Resident R12, R2, and R24 no longer reside in facility. All residents in which Medicare part A ends and the resident remains in the facility are issued SNFABN along with Medicare denials according to CMS guidelines. All residents who discharge part A and remain in facility will be audited for compliance. CMS guidelines will be followed. MDS coordinator educated on requirement of SNFABN. Results of audits will be	

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 _____	10/06/2016

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 156	Continued From page 3 8/12/16, and remained in the facility. R12 used 26 days of Medicare A coverage. The facility did not provide R12 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R2 was discharged from Medicare Part A on 5/23/16, and remained in the facility until she discharged on 5/25/16. R2 used 35 days of Medicare A coverage. The facility did not provide R2 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R9 was discharged from Medicare Part A on 5/26/16, and remained in the facility. R9 used 39 days of Medicare A coverage. The facility did not provide R9 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R24 was discharged from Medicare Part A on 8/16/16, and remained in the facility. R24 used 40 days of Medicare A coverage. The facility did not provide R24 and/or his legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. During an interview on 10/06/2016 at 10:33 a.m. registered nurse (RN)-A stated the facility stopped providing the SNFABN to residents in the	F 156	reported at quality council. DON or designee will provide data to QC.	

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 _____	10/06/2016

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 156	Continued From page 4 facility as they were told it was no longer required. RN-A stated it was brought to her attention through the survey process the SNFABN notices were required for residents that remained in the facility. RN-A stated she would re-implement the process immediately. The facility policy related to SNF (skilled nursing facility) DETERMINATION ON CONTINUED STAY was requested but not provided.	F 156		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 280	R126's care plan has been updated and	11/15/16

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 _____	10/06/2016

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 280	Continued From page 5 review, the facility failed to revise the care plan for the use of an indwelling Foley catheter for 1 of 3 residents (R126) reviewed for urinary catheter use. Findings include: R126's current physician orders, included an order with the start date of 8/3/16, for change catheter monthly and as needed if occluded with 14 French catheter with 10 cc (cubic centimeters) balloon for disorder of urinary system, retention of urine and Foley catheter output every shift. R126's Treatment Administration Record dated from 9/6/16 to 10/6/16, indicated the Foley catheter was changed on the third day of each month and documented signatures for the catheter output every shift as ordered. On 10/4/16, at 9:16 a.m. R126 was observed to be seated in her wheelchair and had a urinary catheter drainage bag hanging underneath her wheelchair. During interview, on 10/4/16, at 10:25 a.m., registered nurse (RN)-B stated R126 had an indwelling Foley catheter and the reason for the catheter was disorder urinary system and urinary retention. R126's care plan problem start date 5/27/16, included problem: toileting/continence, limited in ability to toilet self-related to weakness. R126 is incontinent of bladder and bowel with interventions of assist with incontinence care if incontinent, inspect condition of perineal area after each incontinent episode, report any redness, rash, or broken area, use barrier cream	F 280	reviewed on Nov 8th, 2016. All care plans including catheter problem areas will be audited for accuracy and corrected by Nov 15, 2016. The facility will identify other residents by requiring the nurse managers to run the Matrix Facility Activity report for New Orders daily Mon-Friday and Sat–Mon to be ran on Monday. This report will list all new orders for each resident and will cue to the nurse as to significant changes and/or care plans needs for each resident on their unit. Systemic change will occur as the Facility Activity Report will be required as a tool to manage and will be mandatory utilized an ongoing manner. D.O.N. to audit each managers Facility Activity Reports for completion and follow through on the care plan weekly for one month and monthly for 2 months. Results of audit will be reported at the monthly Quality council meeting. DON or the designee will provide data for Quality Council. Licensed staff will be educated on the importance of care plans and the need for comprehensive goals and objectives as well as the requirement to utilize the Facility Activity Report by Nov 15, 2016.	

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 _____	10/06/2016

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 280	Continued From page 6 as needed and provide extensive assistance for toileting. R126's care plan failed to be revised to include the use of an indwelling Foley catheter and interventions related to the catheter use. On 10/06/16, at 10:29 a.m., RN-B verified R126's care plan failed to identify R126 had in indwelling Foley catheter and interventions related to the catheter use. RN-A stated R126's indwelling Foley catheter was reinserted on 8/3/16. On 10/06/16, at 3:30 p.m., the director of nursing stated she would expect use of a Foley catheter to be care planned, which included reasons identified why the catheter was in use and interventions associated with the use of the catheter. A policy for revision of care plan was requested, but not provided.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to ensure a temporary care plan had been developed following admission and before the comprehensive care plan is developed to have included high risk for bleeding/bruising for 1 of 3 residents (R129) due to use of a blood thinner. Findings include: R129 diagnosis found on the resident face sheet identifies unspecified atrial fibrillation.	F 281	R129 skin risk assessment was completed on 9/15/2016. Temporary care plan will be revised to include bleeding/bruising risk factors by 11/15/2016. New admission temporary care plans will include bleeding/bruising risk factors. This will allow staff to identify those at risk. Initial body audit will identify bruising present upon admission. Weekly	11/15/16

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 _____	10/06/2016

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 281	Continued From page 7 R129 has physician orders for Aspirin 81 mg daily and Coumadin 2 mg daily. Internal Medicine progress note dated 9/21/16, indicates R129 to have an INR level of 1.7 with target INR (international normalized ratio) range of 2 to 3. Coumadin at that time was increased to 2.5 mg daily. Note indicates if any unusual bleeding or bruising develops that an appointment must be scheduled to recheck INR level. R129 was admitted to the facility on 9/15/16. A temporary care plan was put in place upon admission. Temporary care plan did not identify R129's risk for bruising or bleeding related to physician ordered medications of Aspirin and Coumadin. Interview on 10/6/16, at 11:30 a.m. with Licensed practical nurse (LPN)-C and registered nurse (RN)-C stated R129's initial care plan did not include being at risk for bruising and stated that they would get it care planned. LPN-C and RN-C stated typically residents who are at risk for bruising their care plans reflect that. LPN-C and RN-C stated bruises are monitored weekly and that an aide and nurse complete the body audit sheet. When a bruise is identified the nurse will fill out an event on the bruise, determine how the bruise occurred and put in a nurse's order to monitor daily until it's resolved. LPN-C and RN-C also stated the weekly skin assessment should include the measurements of the bruise. Care plan dated 10/6/16 was developed following surveyor inquiring bleeding risks was produced by the facility and it identified R129 receives anticoagulant therapy for diagnosis of Atrial fibrillation and is at risk for bruising/bleeding. Care plan identifies R129 is to be monitored for signs of active bleeding including bruising.	F 281	body audits will monitor status of bruising. Admission nurse and bridge nurses will be educated on identifying bruising/bleeding risk factors by 11/15/2016. MDS Coordinator will audit for compliance during time of admission MDS. Results of audits will be reported at quality council. DON or designee will provide data for QC.	

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 _____	10/06/2016

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 281	Continued From page 8 Facility policy for care plans does not include information related to the initial plan of care.	F 281		
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 follow the care plan for identifying and monitoring bruises for 1 of 3 residents (R61) reviewed for non-pressure related skin concerns and failed to follow the care plan for interventions for pressure related skin conditions for 1 of 3 residents (R47) reviewed for pressure ulcers. Findings Include: R61's comprehensive care plan dated 12/4/15 indicated problem: Resident bruises easily related to Plavix administered for history of Cerebral infarction and history of bruising. Approaches included: Nursing to continue to monitor for bruising, notify physician as needed. Measure and record description of bruise (location, size, length and width, color, surrounding skin, presence/absence of pain, presence/absence of signs of healing. Monitor and record any complaints of pain: location, duration, quantity, quality, alleviating factors, aggravating factors. R61 was observed on 10/4/16, at 9:55 a.m., R61 had bruises to the top of her hands. R61's record	F 282	R61 and R47 had their care plans reviewed. Care plans will be revised as needed. Skin risk assessments reviewed for both residents. Weekly body audits will be used by nursing staff as a tool to identify new and monitor existing skin integrity issues. All care plans including skin risk problem areas will be reviewed for accuracy quarterly per MDS schedule. Review of POC (Point of Care profile) for care plan interventions will be provided for direct care staff by 11/15/2016. Random sling placement compliance audits will be completed biweekly for 4 weeks to monitor compliance. Results of audits will be reported at quality council. DON or designee will provide data for QC.	11/15/16

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 _____	10/06/2016

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 282	Continued From page 9 did not reflect identification or monitoring of the bruises. On 10/05/2016, at 11:58 a.m. licensed practical nurse (LPN)-A verified through observation R61 to have bruising on the top of her left and right hands. LPN-A stated she would measure the bruises and implement monitoring for any swelling, pain and healing. LPN-A stated staff should monitor for bruises daily during cares. LPN-A verified the bruises were not documented on the bath sheet dated 10/4/16 and stated did not note the bruises on R61's hands during the skin inspection she completed on 10/4/16. LPN-A stated R61 bruised easily and stated she just documented on anything new she sees on the resident on the bath sheets. LPN-A stated R61 bruises easily and we don't document on all of the bruises. On 10/05/2016, at 12:52 a.m. the director of nurses (DON) stated if there are any new or unexplained bruises staff should notify the nurse and an event was created if there was an unexplained bruise. The DON stated staff should monitor skin for changes during personal cares and during baths and stated staff should document any skin changes, which included bruising. The DON stated if R61 had bath yesterday, she would have expected the bath sheets to have reflected the bruising to R61's hands. The DON stated the nursing assistants are to document on the bath sheets and the nurse is also to complete a skin check on bath days and should document any skin concerns found on the bath day. The DON stated she expected staff to follow the care plan for identifying and monitoring of bruises. Using the Care Plan Policy dated August 2006	F 282		

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 _____	10/06/2016

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 282	Continued From page 10 included: certified nursing assistants (CNA's) are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. Other staff noting a change in the resident's condition must also report those changes to the Nurse Supervisor and/or the Minimum Data Set (MDS) Assessment Coordinator. Documentation must be consistent with the resident's care plan. R47's care plan, revised 10/04/16, indicated problem pressure ulcers: resident has stage three pressure ulcer on left heel. Approaches included: administer scheduled pain medication as ordered to alleviate pain PRN (as needed), Dycem (non-slip pad) in wheelchair at all times, lamb's wool boots to BLE (bilateral lower extremities), Air pressure mattress applied to bed to relieve pressure, float heels while in bed with heel floater mat, floor nurses/wound NP (nurse practitioner) to perform wound care as ordered, monitor for healing, signs/symptoms of infection. Problem start date revised 10/6/16, pressure ulcer skin integrity: resident is at risk for skin breakdown related to incontinence, diagnosis of dementia, and the overall need for assistance with activities of daily living, turn and reposition every two hours and PRN, remove Hoyer sling from under resident when up in wheelchair and in bed. Do not leave Hoyer sling under resident. Conduct a systematic skin inspection during daily cares. Pay particular attention to the bony prominences. Report concerns to nursing for prompt treatment. Keep clean and dry as possible. Minimize skin exposure to moisture. Provide incontinence care after each incontinent episode and use briefs to maintain personal hygiene and dignity when incontinent.	F 282		

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 _____	10/06/2016

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 282	Continued From page 11 On 10/5/16, at 7:08 a.m., R47 was observed to be in his room, dressed and sitting in his wheelchair with the Hoyer sling underneath him. At 7:55 a.m., R47 remained seated in his wheelchair with the Hoyer sling underneath him. At 8:41 a.m., R47 remained seated in his wheelchair in the dining room with the Hoyer sling underneath him and wellness coach (WC)-A was assisting R47 with eating. At 9:00 a.m., WC-A was observed to be pushing R47 in his wheelchair to the activity room, the Hoyer sling remained underneath R47. WC-A stated she had assisted R47 immediately after feeding him to the activity room. At 9:46 a.m., R47 remained seated in his wheelchair with the sling underneath him in the activity room. At 9:53 a.m., R47 was not in the activity room and WC-B stated she had assisted R47 from the activity room immediately to the chapel area for bible study. WC-B stated R47 had not been repositioned. At 9:53 a.m., WC-A confirmed R47 had not been repositioned when WC-A had assisted R47 from the dining room to the activity room. At 9:55 a.m., nursing assistant (NA)-F stated she had assisted NA-E to transfer R47 into his wheelchair after NA-E had dressed R47 during a.m. cares. NA-F confirmed she had not repositioned R47 since. NA-E confirmed she had completed a.m. cares for R47 and had stated the last time she had repositioned R47 had been after she had dressed R47 this morning. NA-E confirmed she had not repositioned R47 since. At 9:58 a.m., WC-A was pushing R47 down the hallway towards his room and stated that was my fault they did not reposition R47 as I brought him to the wellness activity and then he went to bible study. On 10/5/16, at 12:04 p.m., NA-E confirmed the	F 282		

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 _____	10/06/2016

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 282	Continued From page 12 Hoyer sling was underneath R47 while R47 was seated in his wheelchair. NA-E stated as far as I know we always leave the sling underneath R47 when he is seated in his wheelchair, I have not been told different. On 10/06/16, at 10:24 a.m., registered nurse (RN)-B verified R47's care plan read the Hoyer sling was to be removed and the resident was to be off loaded every two hours. RN-B stated she would expect R47 to be repositioned every two hours and the Hoyer sling to be removed as care planned. On 10/06/16, at 3:42 p.m., the director of nursing stated she would expect the sling to be removed and the resident to be off loaded every two hours per the plan of care. A policy for following the care plan was requested, but not provided.	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 document review the facility failed to identify and monitor bruising for 3 of 3 residents (R61, R92 and R129)	F 309	R61, R92, and R129 had their skin risk assessments reviewed. Assessments will be revised as needed. Weekly body audits	11/15/16

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 _____	10/06/2016

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 309	Continued From page 13 reviewed for non-pressure related skin concerns. Findings Include: R61 was observed on 10/4/16, at 9:55 a.m., R61 had bruises to the top of her hands. R61's record did not reflect identification or monitoring of the bruises. R61's care plan dated 12/4/15 indicated problem: Resident bruises easily related to Plavix administered for history of Cerebral infarction and history of bruising. Approaches included: Nursing to continue to monitor for bruising, notify physician as needed. Measure and record description of bruise inlcuding, location, size, length and width, color, surrounding skin, presence/absence of pain, presence/absence of signs of healing. Monitor and record any complaints of pain, location, duration, quantity, quality, alleviating factors, aggravating factors. R61's progress notes were reviewed from 9/5/16 to 10/5/16 the documentation did not reflect identification or monitoring of the bruises. R61's bath sheet dated 10/4/16 indicated no skin concerns. On 10/05/2016, at 11:58 a.m. licensed practical nurse (LPN)-A verified through observation R61 to have bruising on the top of her left and right hands. LPN-A stated she would measure the bruises and implement monitoring for any swelling, pain and healing. LPN-A stated staff should monitor for bruises daily during cares. LPN-A verified the bruises were not documented on the bath sheet dated 10/4/16 and stated did not note the bruises on R61's hands during the skin inspection she completed on 10/4/16. LPN-A stated R61 bruised easily and stated she just documented on anything new she sees on the	F 309	will be used by nursing staff as a tool to identify new and monitor existing skin integrity issues. Resident examination and assessment policy will be reviewed with nursing staff by 11/15/2016. Weekly body audit tool will be audited randomly twice weekly for 4 weeks to ensure compliance. Results of audits will be reported at quality council. DON or designee will provide data for QC.	

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 _____	10/06/2016

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 309	Continued From page 14	F 309		

resident on the bath sheets. LPN-A stated knows R61 bruises easily and we don't document on all of the bruises.
R61's progress note dated 10/5/16 indicated, "Resident noted to have bruising to bilateral hands. Bruise to left hand purple in color measuring 7 cm [centimeter] x 3.5 cm. Skin intact. No swelling. Right hand bruise purple measuring 1.2 cm x 0.7 cm. Skin intact. No swelling. Resident denied pain r/t [related to] bruising. When asked how bruising happened, resident stated "I bruise so easy," "I probably bumped them again." Resident appears to be resting comfortably in recliner with call light accessible. Note left for NP [nurse practitioner]. Will continue to monitor."
On 10/06/2016, at 10:01 a.m. nursing assistant (NA)-C stated she looked at resident's skin daily with cares, looking for any changes. NA-C stated she notified the nurse when she found any skin concerns during cares. NA-C stated on bath days the bath aide documented any skin concerns on the bath sheet and stated the nurse looked over the bath sheet and signed it.

On 10/05/2016, at 12:52 a.m. the director of nurses (DON) stated if they are any new or unexplained bruises staff should notify the nurse and an event was created if there was an unexplained bruise. The DON stated staff should monitor skin for changes during personal cares and during baths and stated staff should document any skin changes, which included bruising. The DON stated if R61 had bath yesterday, she would have expected the bath sheets to have reflected the bruising to R61's hands. The DON stated the nursing assistants are to document on the bath sheets and the nurse is also to complete a skin check on bath

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 _____	10/06/2016

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 309	Continued From page 15	F 309		

days and should document any skin concerns found on the bath day. The DON stated staff should follow the care plan for identifying and monitoring for bruises.

A policy was requested for monitoring non-pressure related skin concerns and was not provided by the facility.

R92 was observed on 10/04/16, at 10:18 a.m. R92 had a bruise located on her right hand between her middle finger and ring finger. R92's record did not reflect identification or monitoring of the bruise.

On 10/06/16, at 11:21 a.m., during observation, registered nurse (RN)-B confirmed R92 had a bruise on located on her right hand between her middle finger and ring finger. RN-B confirmed R92's record lacked identification or monitoring of the bruise. RN-B stated the facility system was when a skin concern is noticed the nurse was to be informed. The nurse then would create an event in the computer system to monitor the bruising weekly until resolved.

R92's care plan dated revised 6/6/16, indicated problem: at risk for skin breakdown related to needing assistance with cares, increased incontinence and increased weakness. Approaches included: conduct a systematic skin inspection during daily cares. Pay particular attention to the bony prominences. Report concerns to nursing for prompt treatment. Problem: receives anticoagulant therapy, at risk for bruising and bleeding. Approaches included observe for signs of active bleeding, protect from injury/trauma, administer medication as ordered,

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 _____	10/06/2016

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 309	Continued From page 16	F 309		

encourage to wear long sleeves if tolerable and monitor labs and vital signs.
R92's progress notes were reviewed from 9/1/16 to 10/4/16 the documentation did not reflect identification or monitoring of the bruise.

On 10/06/16, at 3:43 p.m., the DON stated the staff were to notify the nurse regarding any change with skin on a daily basis, so the nurse can investigate further.
R129 diagnosis found on the resident face sheet identifies unspecified atrial fibrillation.
R129 has physician orders for Aspirin 81 mg daily and Coumadin 2 mg daily.
Internal Medicine progress note dated 9/21/16, indicates R129 to have an International Normalized Ratio (INR) level of 1.7 with target INR range of 2 to 3. Coumadin (reduces clotting time) at that time was increased to 2.5 mg daily. Note indicates if any unusual bleeding or bruising develops that an appointment must be scheduled to recheck INR level.
R129 was admitted to the facility on 9/15/16. A temporary care plan was put in place upon admission. Temporary care plan did not identify R129 ' s risk for bruising or bleeding related to physician ordered medications of Aspirin and Coumadin.
Initial Nursing Body Audit form dated 9/15/16, indicates R129 to have bruising to the right forearm and left wrist. No measurements included. Weekly body audits form taken from the CNA (certified nursing assistant) book dated 9/16/16 and 10/4/16 indicates R129 to have no bruising with only a CNA signature. Weekly body audits provided to survey team on 10/6/16 after concerns were brought to facility attention indicates form to now have both a CNA and a licensed nursing staff's signature with bruise to

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 _____	10/06/2016

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 309	Continued From page 17 left forearm/wrist identified. On 10/4/16, at 11:27 a.m. R129 was noted to have a large bruise to the top of the left forearm/wrist area. Reviewed progress notes and orders from 9/15/16 to 10/6/16. Bruise to top of left forearm/wrist was not identified or monitored. No order was present to monitor the bruise. Admission note does not indicate bruise to left forearm/wrist area. Interview on 10/5/16, at 7:47 a.m. with nursing assistant (NA)-D stated the bruise was old and had been present for a while. NA-D stated when she finds a bruise she reports to the nurse right away and has the nurse come in and look at it. Interview on 10/5/16, at 8:25 a.m. with licensed practical nurse (LPN)-B stated bruises are monitored weekly during the weekly shower. LPN-B stated R129's baths are on Tuesday mornings with the last bath taking place on 10/4/16. Weekly body audit from 10/4/16 indicated no bruising and identified, "all looked good." LPN-B stated he would measure the bruise. Progress note dated 10/5/16, at 2:43 p.m. identifies bruise to left forearm measures 5 cm x 5 cm. LPN-B did not enter an order for monitoring of the bruise until resolved. Interview on 10/6/16, at 11:30 a.m. with LPN-C and registered nurse (RN)-C stated R129's care plan did not include being at risk for bruising and stated that they would get it care planned. LPN-C and RN-C stated typically residents who are at risk for bruising their care plans reflect that. LPN-C and RN-C stated bruises are monitored weekly and that an aide and nurse complete the body audit sheet. When a bruise is identified the nurse will fill out an event on the bruise, determine how the bruise occurred and put in a nurse's order to monitor daily until it's resolved.	F 309		

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 _____	10/06/2016

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 309	Continued From page 18 LPN-C and RN-C also stated the weekly skin assessment should include the measurements of the bruise. Interview on 10/6/16, at 3:20 p.m. with RN-C stated R129's bruise was from an intravenous needle inserted and used at the hospital and was there on admission. RN-C stated it was documented on the initial body audit form. RN-C stated that orders to monitor bruises aren't entered for bruises that are present on admission on new bruises that occur in the facility. Requested facility policy related to monitoring of skin conditions. Policy titled, "Resident Examination and Assessment" dated 02/2014, indicates, "the purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan" Policy identifies the need to assess for the, "presence of bruises, pressure sores, redness, edema, rashes." Policy identifies, "all assessment data obtained during the procedure" should be recorded in the resident's medical record.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		11/15/16

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 _____	10/06/2016

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 314	Continued From page 19 by: Based on observation, interview and document review, the facility failed to provide every two hour turning and repositioning and removal of a Hoyer sling when seated in a wheelchair as directed by the comprehensive care plan for 1 of 3 residents (R47) identified at risk for pressure ulcers. Findings Include: R47's annual Minimum Data Set (MDS) dated 6/14/16, indicated R47 had severe cognitive impairment, required total assistance with transfers, was at risk for pressure ulcers, currently had one stage two pressure ulcer and one unstageable pressure ulcer. R47's care plan, revised 10/04/16, indicated problem pressure ulcers: resident has stage three pressure ulcer on left heel. Approaches included: administer scheduled pain medication as ordered to alleviate pain PRN (as needed), Dycem (non-slip pad) in wheelchair at all times, lamb's wool boots to BLE (bilateral lower extremities), APM (anti-pressure mattress) applied to bed to relieve pressure, float heels while in bed with heel floater mat, floor nurses/wound NP (nurse practitioner) to perform wound care as ordered, monitor for healing, signs/symptoms of infection. Problem start date revised 10/6/16, pressure ulcer skin integrity: resident is at risk for skin breakdown related to incontinence, diagnosis of dementia, and the overall need for assistance with activities of daily living, turn and reposition every two hours and PRN, remove Hoyer sling from under resident when up in wheelchair and in bed. Do not leave Hoyer sling under resident. Conduct a systematic skin inspection during daily cares. Pay particular attention to the bony	F 314	R47's skin risk assessment will be reviewed and updated by 11/15/2016. R 47's care plan will be reviewed and updated by 11/15/2016. R 47's weekly skin assessment will be updated by 11/11/2016 All residents that need mechanical lifts will be individually assessed for risk and benefits associated with potential skin shear as it relates to removal of the lift sling while the resident is in the wheelchair by 11/15/16. The weekly skin assessment will be revised to include assessment of the skin for risk /benefit of shearing. This assessment will be individualized and based upon the residents' ability to reposition and the additional risk associated with skin shearing. The skin assessment will be turned into the manager and the care plan updated accordingly. Random audits of wheelchair positioning as it relates to placement of the hoyer lift sling will occur weekly for four weeks, two times per month for one month, monthly for one month and as needed thereafter. The audit will include review of the care plan for follow through when indicated. Education of all staff will occur by 11/15/2016 as to the importance of following care plan, providing an individualized assessment as it relates to placement of the hoyer lift sling and risk for skin shearing within the wheelchair. DON to bring results of audits to the monthly quality council meeting.	

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 _____	10/06/2016

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 314	Continued From page 20	F 314		

prominences. Report concerns to nursing for prompt treatment. Keep clean and dry as possible. Minimize skin exposure to moisture. Provide incontinence care after each incontinent episode and use briefs to maintain personal hygiene and dignity when incontinent.

R47's Wound Summary Report dated 9/21/16, indicated pressure wound stage two to three right buttock wound: wound healed.

On 10/5/16, at 7:08 a.m., R47 was observed to be in his room, dressed and sitting in his wheelchair with the Hoyer sling underneath him. At 7:55 a.m., R47 remained seated in his wheelchair with the Hoyer sling underneath him. At 8:41 a.m., R47 remained seated in his wheelchair in the dining room with the Hoyer sling underneath him and wellness coach (WC)-A was assisting R47 with eating. At 9:00 a.m., WC-A was observed to be pushing R47 in his wheelchair to the activity room, the Hoyer sling remained underneath R47. WC-A stated she had assisted R47 immediately after feeding him to the activity room. At 9:46 a.m., R47 remained seated in his wheelchair with the sling underneath him in the activity room. At 9:53 a.m., R47 was not in the activity room and WC-B stated she had assisted R47 from the activity room immediately to the chapel area for bible study. WC-B stated R47 had not been repositioned. At 9:53 a.m., WC-A confirmed R47 had not been repositioned when WC-A had assisted R47 from the dining room to the activity room. At 9:55 a.m., nursing assistant (NA)-F stated she had assisted NA-E to transfer R47 into his wheelchair after NA-E had dressed R47 during a.m. cares. NA-F confirmed she had not repositioned R47 since. NA-E confirmed she had completed a.m. cares for R47 and had stated

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 _____	10/06/2016

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 314	Continued From page 21 the last time she had repositioned R47 had been after she had dressed R47 this morning. NA-E confirmed she had not repositioned R47 since. At 9:58 a.m., WC-A was pushing R47 down the hallway towards his room and stated that was my fault they did not reposition R47 as I brought him to the wellness activity and then he went to bible study. On 10/5/16, at 12:04 p.m., NA-E confirmed the Hoyer sling was underneath R47 while R47 was seated in his wheelchair. NA-E stated as far as I know we always leave the sling underneath R47 when he is seated in his wheelchair, I have not been told differently. On 10/06/16, at 10:24 a.m., registered nurse (RN)-B verified R47's care plan read the sling was to be removed and the resident was to be off loaded every two hours. RN-B stated she would expect R47 to be repositioned every two hours and the sling to be removed as care planned. On 10/6/16, at 11;54 a.m., licensed practical nurse (LPN)-D stated R47 had prior pressure ulcers on his buttocks, but the areas healed a couple of weeks ago. On 10/06/16, at 3:42 p.m., the DON stated she would expect the sling to be removed and the resident to be off loaded every two hours per the plan of care. A policy for pressure ulcer skin conditions and following the care plan was requested, but not provided.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		11/15/16

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 _____	10/06/2016

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 329	Continued From page 22 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify specific mood symptoms to determine if an antidepressant was affective for depression for 1 of 5 residents (R103); failed to identify resident specific target behaviors for the use of an antipsychotic medication, complete a comprehensive sleep assessment and document physician justification for the use of melatonin (hormone) for sleep aide for 1 of 5 residents (R57) and failed to identify resident	F 329	R57 sleep log will be completed by 11/8/2016. All residents on melatonin will have a sleep log completed by 11/15/2016. Sleep logs will be reviewed by IDT team. R72 care plan reviewed for target behaviors r/t use of Seroquel. R103 care plan reviewed for target behaviors r/t use of Zoloft. All residents with antidepressants, antianxiety, antipsychotic, and hypnotic	

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 _____	10/06/2016

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 329	Continued From page 23 specific symptoms for use of an anti-anxiety medication to determine if it is affective, also attempt a tapering reduction or document a detailed physician justification as to why tapering was contraindicated at this time for the use of an antipsychotic and antidepressant medications for 1 of 5 residents (R72) reviewed for unnecessary medications. Findings include: R103 LACKED RESIDENT SPECIFIC MOOD SYMPTOMS TO DETERMINE IF ANTIDEPRESSANT WAS AFFECTIVE: R103's quarterly Minimum Data Set (MDS), dated 6/28/16, indicated R103 was cognitively intact, had diagnoses of anxiety and depression, and moderately severe depression based on resident interview. R103's care plan dated, 6/27/16 indicated Problem: Resident has long history of depression and anxiety and is treated with medications. Approaches included: Social Services will meet with resident quarterly, and as needed, to complete PHQ-9 Assessment (mental health status questionnaire) and provide supportive visit to assist in monitoring resident's mood. Will notify provider of significant concerns in changes in mood. Staff to encourage expression of needs and concerns. Listen and reassure as needed. Resident enjoys 1-1 visits. R103's physician orders included the following orders: Zoloft (antidepressant) 100 mg (milligrams) twice a day dated 8/31/16. Wellbutrin XL (extended release antidepressant) 300 mg daily dated 6/30/16. R103's progress notes were reviewed from 7/1/16	F 329	medications will have target behaviors identified on care plan and in EMAR by 11/15/2016. Licensed staff will educated to document target behaviors within EMAR by 11/15/2016. Target behavior and sleep log compliance will be audited quarterly according to MDS schedule. Results of audits will be reported at quality council. DON or designee will provide data for QC. Addendum: R72's MD was updated on 8/9/2016 the physician reviewed behaviors and identified that the she needed to increase her Seroquel because of behaviors that were escalating. New orders were obtained on 8/9/2016. Because this resident was changed in orders, the dose reduction was not done due to resident's target behavior was still escalating such as hitting out at staff and other residents. The care plan was updated to reflect the target behaviors. It was also noted that Dr. Wallner reviewed resident's plan of care, and stated that she on 9/23/16 she was going to start Cymbalta as well as continuation of the medications. Other residents with drugs such as antidepressants, antianxiety, antipsychotic and hypnotic medication will have target behaviors identified on the TAR by November 15th, 2016. Random audits for completion of target behaviors & dose reductions will be completed by the Unit Managers weekly for one month, two times per month for one month and monthly for one month. Random audits will occur on an as needed basis. Results of audits will be	

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 _____	10/06/2016

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 329	Continued From page 24 to 10/5/16 with no mood concerns identified. On 10/06/2016, at 9:39 a.m. nursing assistant (NA)-A stated resident was very quiet and displayed very little emotion. NA-A stated R103 did not display any mood or behavioral concerns. On 10/06/2016, at 2:00 p.m. nursing assistant (NA)-B stated she had not noticed any mood or behavior concerns for R103. On 10/05/2016, at 9:41 a.m. registered nurse (RN)-B stated specific mood symptoms had not been identified for the use of the antidepressants for R103. RN-B stated staff monitor general mood symptoms and document any mood concerns in the progress notes. RN-B stated the nurses put events into the electronic medical record when there is a medication added or changed and the nurses document each shift for a couple of weeks. RN-B stated if there were changes in mood or behavior during that time, the nurse notified the nurse practitioner for further review. On 10/05/2016, at 12:43 p.m. the director of nurses (DON) stated mood symptoms should be identified and monitored for residents on antidepressants. The DON stated R103's care plan should have identified specific mood symptoms for monitoring. The DON stated by reviewing R103's care plan she was unable to determine what mood concerns R103 had. The DON stated R103's progress notes indicated she was pleasant, cooperative and orientated per her review. On 10/06/2016, at 3:01 p.m. R103 stated her mood symptoms included being tearful and	F 329	provided to the DON for review and reported to the quality council monthly. GDR's will be reviewed quarterly with the primary physician(s) and noted accordingly within the medical record progress notes.	

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 _____	10/06/2016

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 329	Continued From page 25 having crying episodes, feeling overwhelmed and stated she used to go to bed as an escape as life was very overwhelming. R103 stated her crying episodes have stopped after starting her medications. A policy for identifying and monitoring mood symptoms for the use of antidepressants was requested and not provided by the facility. R57 LACKED RESIDENT SPECIFIC TARGET BEHAVIORS IDENTIFIED FOR ANTIPSYCHOTIC MEDICATION: R57's quarterly MDS, dated 8/4/16, indicated R57 was cognitively intact, had moderate symptoms of depression based on resident interview and had no behaviors. R57's current physician orders included an order for risperidone (antipsychotic) 5 mg every bedtime for diagnosis of dementia with behavioral disturbances. R57's current care plan included problem: has diagnosis of major depression with approaches of administer medication as ordered, monitor mood every shift as ordered. Problem psychotropic drug use: at risk for adverse consequences related to receiving antidepressant medication for treatment of depression. Approaches: assess/record effectiveness of drug treatment. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Problem: appears to have a depressed mood/symptoms as indicated by scores obtained on PHQ-9 (depression scale). Social Services will meet with resident quarterly, and as needed, to complete PHQ-9 assessment and provide supportive visit to assist in monitoring resident's mood. Allow resident to have control	F 329		

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 _____	10/06/2016

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 329	Continued From page 26 over situations as possible. Convey an attitude of acceptance toward resident, listen and reassure as needed. Psychiatrist consult for depression and dementia presumed w/o (without) psychosis. Encourage resident to be involved with facility life. Encourage resident to continue with daily decision making as able to do so. Encourage verbalization of feelings. R57's care plan failed to identify specific target behaviors and interventions related to the use of an antipsychotic medication. On 10/06/16, at 11:00 a.m., RN-B reviewed R57's care plan and confirmed R57's care plan lacked specific target behaviors and interventions related to the use of the antipsychotic medication. On 10/06/16, at 3:45 p.m., the DON stated she would expect target behaviors to be identified and interventions implemented for the use of an antipsychotic medication. A policy for the use of antipsychotic medication was requested, but not provided. R57 LACKED COMPREHENSIVE SLEEP ASSESSMENT BEFORE STARTING HYPNOTIC; ONGOING MONITORING OF SLEEP FOR EFFECTIVENESS OF HYPNOTIC MEDICATION AND THE USE OF NON-PHARMACOLOGICAL INTERVENTIONS BEFORE GIVING HYPNOTIC FOR SLEEP R57's current physician orders included an order for melatonin 3 mg two hours prior to bedtime for diagnosis of insomnia, start date 5/5/16. R57's current care plan not dated, included,	F 329		

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 _____	10/06/2016

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 329	Continued From page 27 Problem: experiences insomnia/change in usual sleep pattern. Approaches: administer medications as ordered. Monitor and record effectiveness. Monitor and report any adverse side effects. Discourage daytime napping. Limit caffeine intake. Provide comfortable environment to promote sleep (clean bedding, comfortable bed clothing, incontinence care, comfortable temperature, ventilation). Reduce environmental disruptions (noise, staff disruptions, intercom, light). R57's physician progress notes dated 5/17/16 through 8/17/16, identified medications included melatonin 3 mg daily two hours prior to bedtime. On 10/06/16, at 11:00 a.m., RN-B was asked for a sleep assessment, non-pharmacological interventions used for sleep and monitoring melatonin for effectiveness for sleep. RN-B was unable to provide any of this information. On 10/06/16, at 3:45 p.m., the DON stated we monitor sleep habits three to five days after admission. The DON reviewed R57's record and stated I do not see any documentation in R57's record for non-pharmacological interventions attempted for sleep or documentation of sleep hours prior to starting the melatonin. A policy for sleep assessment was requested, but not provided. R72 LACKED RESIDENT SPECIFIC MOOD SYMPTOMS TO JUSTIFY THE USE AN ANTI-ANXIETY MEDICATION. JUSTIFICATION FOR STARTING AN ANTIDEPRESSANT MEDICATION AND LACK OF A GRADUAL DOSE REDUCTION (GDR) FOR USE OF AN	F 329		

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 _____	10/06/2016

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 329	Continued From page 28 ANTIPSYCHOTIC MEDICATION OR A COMPREHENSIVE PHYSICIANS JUSTIFICATION FOR NOT ATTEMPTING A GDR AT THIS TIME: R72's quarterly MDS, dated 8/9/16, indicated R72 severe cognitive impairment, had mild symptoms of depression based on resident interview, had no behaviors and received antipsychotic medication. R72's current physician orders included orders for Seroquel (antipsychotic) 25 mg twice daily (increased on 8/9/16) for dementia with behavioral disturbance and Cymbalta (antidepressant) 20 mg once daily for anxiety, start date of 9/20/16. R72's care plan dated 5/9/16, included behavioral symptoms problem: on antipsychotic (atypical) medication related to has socially inappropriate/disruptive behavioral symptoms due to cognitive deficit as evidenced by resident yelling at other residents at meal times, wandering, and yelling at staff. Approaches: Monitor resident for side effects related to use of antipsychotic medication. Nursing to administer Seroquel as ordered. Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Maintain a calm environment and approach to the resident. When resident begins to become socially inappropriate or disruptive, intervene and redirect resident in a calm manner. R72's care plan failed to be revised to address the specific symptoms for diagnosis of anxiety and interventions related to the use of the Cymbalta medication.	F 329		

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 _____	10/06/2016

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 329	Continued From page 29 On 10/6/16 at 11:20 a.m. RN-B was asked for information regarding the clinical rationale for starting Cymbalta and what mood behaviors are being monitored for effectiveness. Also the clinical rational for not attempting a GDR or the physicians comprehensive justification as to why it would be contraindicated at this time. Also R72's physician progress notes lacked documented justification for the start of the Cymbalta medication and lacked documentation of physician justification for the increase in the Seroquel medication or at a minimum to include information as to why any attempted dose reduction for the Seroquel would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. RN-B was unable to provide this information. On 10/06/16, at 3:36 p.m., the DON stated she would expect the physician to document the reason for the use of the Cymbalta medication and for the increase use of the Seroquel. The DON stated she would expect the care plan to be revised for the use of the Cymbalta and specific symptoms for anxiety to be identified. A policy for use of psychotropic medications and physician justification was requested, but not provided.	F 329		
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	F 441		11/15/16

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 _____	10/06/2016

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 441	Continued From page 30 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 review, the facility failed to follow manufactures recommendations for cleaning/sanitizing and store nebulizer equipment to prevent infection for	F 441	R61 nebulizer tubing and reservoir was replaced. Tubing and reservoir is replaced weekly. All residents who receive nebulizer treatments have their tubing and	

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 _____	10/06/2016

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 441	Continued From page 31 1 of 2 residents (R61); failed to ensure proper hand hygiene was followed to prevent the spread of infection during the provision of perineal-care for 1 of 3 residents (R126) reviewed for urinary catheter use and failed to ensure ice machine chutes and water spigots were properly sanitized/cleaned and maintained for 3 of the 4 units (Aspen, Oak, Dawn) kitchenettes in the facility this had the potential to affect all 59 residents on these wings, staff and visitors. Findings include: R61 LACKED SANITIZING/STORAGE OF NEBULIZER EQUIPMENT: During an initial tour of the facility on 10/3/16, at 1:37 p.m., on the Dawn Unit, R61's nebulizer machine was observed to be located on the nightstand. It was connected to tubing with a mask and medication reservoir attached. There was observed to be moisture in the medication reservoir. On 10/05/16, at 8:47 a.m. and 9:44 a.m., R61's nebulizer machine was observed to be located on the nightstand. It was connected to tubing with a mask and medication reservoir attached. There was observed to be moisture in the medication reservoir. At 11:13 a.m., during medication observation, trained medication aide (TMA)-A entered R61's to administer ipratropium-albuterol (bronchodilator) solution by nebulization. R61's nebulizer equipment remained the same. TMA-A verified R61's nebulizer equipment was connected to tubing with a mask and medication reservoir attached and there was observed to be moisture in the medication reservoir. When queried regarding cleaning of the nebulizer equipment after use, TMA-A stated I should have	F 441	reservoir replaced weekly and PRN. Reservoirs are cleaned per manufacturer's recommended guidelines after each administration of a nebulizer treatment. Audits of nebulizers reservoirs will be completed weekly for one month, two times per month for one month, and monthly for one month. Audits will be reviewed and reported to the quality council monthly by the DON or designee. Audits will be reviewed by IDT team. Licensed staff and TMAs will review manufacture's guidelines for cleaning of nebulizer medication reservoirs and tubing by 11/15/2016. Infection control tracking and audits of Peri Care have continued as standard of practice for Koda Living Community. Staff have education related to infection control, usage/changing of gloves as well as peri care upon hire, annually, through facility skills fair, and on an as needed based per Infection Control Preventionist. Direct care staff will have additional education by 11/10/2016. Audits for Peri care will be performed weekly for one month, two times per month for one month and monthly for one month. Audits will be reviewed and reported to the quality council monthly by the DON or designee. Results will be provided to QC by DON or designee. Chutes for ice in Aspen, Oak, and Dawn will be replaced by 11/15/2016. Chutes will be replaced as needed. Chutes will be audited weekly for cleanliness by administrator or designee. DON or designee will provide data for QC.	

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 _____	10/06/2016

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 441	Continued From page 32	F 441		

cleaned the equipment after administration of R61's medication this a.m. TMA-A stated I usually clean the equipment between use and would use warm water to rinse the equipment. When queried if any other residents had received nebulizer medication during the morning medication pass, TMA-A replied she had administered R69's nebulizer medication. Observation with TMA-A at the time revealed R69's nebulizer equipment was connected to a nebulizer machine and moisture was observed in the medication reservoir. TMA-A verified she had not cleaned the equipment after use. TMA-A stated the facility policy was to clean the equipment between use.

R61's Resident Face Sheet, dated 10/6/16, indicated R61 had a diagnosis of wheezing. R61's medication administration record, dated from 9/7/16 to 10/6/16, identified R61 was administered ipratropium-albuterol solution for nebulization 0.5 mg (milligrams)-3 mg, one vial on 10/5/16 at 8:00 a.m. and 12:00 p.m., and documentation of the administration of the medication was signed by TMA-A.

On 10/06/16, at 3:29 p.m., the director of nursing (DON) stated she would expect staff to clean the nebulizer equipment after use by rinsing in warm water and air dry the equipment.

A facility policy for cleaning nebulizer equipment was requested, but not provided.

R169 RECEIVED PERINEAL CARE WITHOUT STAFF SANITIZING HANDS AFTER SOILING WITH STOOL AND BEFORE APPLYING CREAM TO BUTTOCKS:

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 _____	10/06/2016

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 441	Continued From page 33 On 10/05/16, at 7:55 a.m., nursing assistant (NA)-E was observed to apply gloves, cleansed R169's front peri area, rolled R169 over and cleansed bowel movement from R169's buttocks. R169's roommate opened the door to the room and NA-E with soiled gloves on pulled the privacy curtain for R169's side of the room closed. NA-E with soiled gloves on picked up a tube of barrier cream, applied the cream to R169's buttocks and applied a clean incontinent product onto R169. NA-E then removed the soiled gloves and washed hands. NA-E failed to remove soiled gloves and wash hands prior to touching other items. On 10/06/16, at 10:29 a.m., registered nurse (RN)-B stated gloves should be removed and hands washed after providing peri cares. On 10/06/16, at 3:30 p.m., the DON stated she would expect after providing peri-care gloves be removed and hands washed. The facility policy Perineal Care, dated revised 10/10, included Steps in the Procedure: 7. Put on gloves, 9. b. Wash the perineal area, wiping front to back, e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks, 11. Discard disposable items into designated containers, 12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. LACK OF THOROUGH SANITIZING ICE MACHINE DUE TO BUILD UP ON ICE CHUTE/SPIGOT BUILD UP:	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 _____	10/06/2016

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 441	Continued From page 34 On 10/03/16, at 5:04 p.m., observation of the Aspen Unit ice machine revealed a white substance build up on the plastic dispenser ice chute and the water spigot. Nursing assistant (NA)-G was observed to put ice into a glass from the ice machine and confirmed at the time the ice chute and water spigot had a white substance build up. Licensed practical nurse (LPN)-E confirmed the ice machine ice chute and water spigot had a white substance build up. LPN-E stated she did not know who was responsible for cleaning of the ice machine. Observation of kitchenette ice machine in the Oak unit on 10/3/16, at 4:43 p.m. found the ice chute to have a large amount of gray/light brown colored buildup on the inside and around the entire chute. At this time observed facility staff to be removing ice from the chute and serving to the residents in the dining room. Observation of kitchenette ice machine in dawn unit on 10/04/2016, 10:31 a.m. found the ice chute to have gray/light brown/white colored buildup on the inside and around the chute. Interview and observation on 10/6/16, at 2:03 p.m. with the Environmental Services Director (ESD) verified the ice chutes to have scale build up present. The ESD stated the culinary department takes care of the ice machines and stated the chute is wiped down daily with regular soapy water and is cleaned weekly with a vinegar treatment. The ESD stated there was a quote out to John's appliance for new fixtures since the vinegar isn't cleaning them. Interview on 10/6/16, at 3:24 p.m. with the Culinary Services Director (CSD) stated she had tried to get the chutes replaced since the facility has extremely hard water. The CSD stated she had been trying to get quotes from John's	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 _____	10/06/2016

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 441	Continued From page 35 appliance. The CSD stated the chutes are being cleaned daily with warm soapy water and vinegar is used weekly. The CSD stated there wasn't a cleaning schedule to alert the culinary staff of when the chutes needed to be cleaned but stated the staff know to clean on Friday's. The CSD stated there had been a quote six months ago but the quote had been denied at that time due to the expense and only the chutes had been replaced. Facility provided a quote from John's Appliance dated 10/6/16, which identified that the ice chutes had not been previously replaced. Facility policy titled, "Cleaning Procedures" dated 1/13, identifies the water/ice dispenser, wash and rinse the exterior and catch tray of the dispenser. Sanitize at the appropriate PPM dilution. Clean and de-lime catch tray and nozzles as needed. Facility policy titled, "Cleaning Schedule" undated, identifies cleaning schedules with all cleaning tasks listed will be provided in the department and cleaning tasks completed in a timely and appropriate manner. Policy identifies completed cleaning schedules are to be kept on file for six months. Facility provided one form dated 10/4/16 that identifies the water and ice machines were cleaned in the Oak unit.	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 **02 - KODA LIVING COMMUNITY** B. WING _____	**10/05/2016**

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
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 dated 10/5/2016, 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		11/02/2016

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

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 _____	**10/05/2016**

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
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 77 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the	K 011		11/15/16

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 _____	**10/05/2016**

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
K 011	Continued From page 2 addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 11/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 11/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 On facility tour between 10:00 AM and 02:00 PM on 10/5/2016, based on observation and interview revealed that the link to Hospital and Nursing home has a fire rated door that do not fit tight in frame. This deficient practice could affect the safety of all residents, staff and vistors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 011	A new rubber gasket has been ordered for the fire rated door that is located in the link hallway connecting Koda to the Owatonna Hospital. The new rubber gasket will replace the worn/ineffective seal. This update will be completed by 11/15/2016.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be	K 018		11/15/16

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 _____	**10/05/2016**

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
K 018	Continued From page 3 prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 On facility tour between 10:00 AM and 02:00 PM on 10/5/2016, based on observation and interview revealed that room 521 has a fire rated doors that do not fit tight in frame. This deficient practice could affect the safety of the (16) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 018	The current door seal for room 521 was adjusted to eliminate the gap, bringing the door into compliance. This was completed on 10/19/2016.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. On facility tour between 10:00 AM and 02:00 PM on 10/5/2016, based on observation and interview revealed that the emergency lighting unit for the mechanical room does not light when tested and	K 046	The emergency lighting unit in the mechanical room was tested and found to need 2 new batteries. Two new batteries were replaced and the unit is functioning properly. A new process was established for testing emergency lighting function. Findings will be documented on a monthly and yearly basis. This was completed on	11/15/16

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 _____	**10/05/2016**

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
K 046	Continued From page 4 have no documentation of monthly and annual testing. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 046	10/18/2016.	
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 On facility tour between 10:00 AM and 02:00 PM on 10/5/2016, based on observation and interview revealed or based that there are missing ceiling tiles in the electrical room for the Dawn wing. This deficient practice could affect the safety of the (20) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 062	The ceiling tile in the electrical room in our Dawn neighborhood was replaced on 10/10/2016.	11/15/16

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
October 24, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5426028 and Complaint Number H5426025

Dear Mr. Vandergon:

The above facility was surveyed on October 3, 2016 through October 6, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5426025. that was found to be unsubstantiated. 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 contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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

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 _____	10/06/2016

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) COMPLETE DATE
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		

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 _____	C 10/06/2016

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) COMPLETE DATE
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		

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 _____	C 10/06/2016

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) COMPLETE DATE
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 October 3, 4, 5 & 6, 2016, 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		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. "In addition, complaint investigation(s) were also completed at the time of the licensing survey." An investigation of complaint H5426025 was completed. The complaint was not substantiated.	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 follow the care plan for identifying and monitoring bruises for 1 of 3 residents (R61) reviewed for non-pressure related skin concerns and failed to follow the care plan for interventions for pressure related skin conditions for 1 of 3 residents (R47) reviewed for pressure ulcers. Findings Include: R61's comprehensive care plan dated 12/4/15 indicated problem: Resident bruises easily related to Plavix administered for history of Cerebral infarction and history of bruising. Approaches	2 565	Corrected	11/15/16

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 _____	C 10/06/2016

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) COMPLETE DATE
2 565	Continued From page 3	2 565		

included: Nursing to continue to monitor for bruising, notify physician as needed. Measure and record description of bruise (location, size, length and width, color, surrounding skin, presence/absence of pain, presence/absence of signs of healing. Monitor and record any complaints of pain: location, duration, quantity, quality, alleviating factors, aggravating factors.
R61 was observed on 10/4/16, at 9:55 a.m., R61 had bruises to the top of her hands. R61's record did not reflect identification or monitoring of the bruises.
On 10/05/2016, at 11:58 a.m. licensed practical nurse (LPN)-A verified through observation R61 to have bruising on the top of her left and right hands. LPN-A stated she would measure the bruises and implement monitoring for any swelling, pain and healing. LPN-A stated staff should monitor for bruises daily during cares. LPN-A verified the bruises were not documented on the bath sheet dated 10/4/16 and stated did not note the bruises on R61's hands during the skin inspection she completed on 10/4/16. LPN-A stated R61 bruised easily and stated she just documented on anything new she sees on the resident on the bath sheets. LPN-A stated R61 bruises easily and we don't document on all of the bruises.

On 10/05/2016, at 12:52 a.m. the director of nurses (DON) stated if there are any new or unexplained bruises staff should notify the nurse and an event was created if there was an unexplained bruise. The DON stated staff should monitor skin for changes during personal cares and during baths and stated staff should document any skin changes, which included bruising. The DON stated if R61 had bath yesterday, she would have expected the bath sheets to have reflected the bruising to R61's

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 _____	C 10/06/2016

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) COMPLETE DATE
2 565	Continued From page 4	2 565		

hands. The DON stated the nursing assistants are to document on the bath sheets and the nurse is also to complete a skin check on bath days and should document any skin concerns found on the bath day. The DON stated she expected staff to follow the care plan for identifying and monitoring of bruises.

Using the Care Plan Policy dated August 2006 included: certified nursing assistants (CNA's) are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. Other staff noting a change in the resident's condition must also report those changes to the Nurse Supervisor and/or the Minimum Data Set (MDS) Assessment Coordinator. Documentation must be consistent with the resident's care plan.

R47's care plan, revised 10/04/16, indicated problem pressure ulcers: resident has stage three pressure ulcer on left heel. Approaches included: administer scheduled pain medication as ordered to alleviate pain PRN (as needed), Dycem (non-slip pad) in wheelchair at all times, lamb's wool boots to BLE (bilateral lower extremities), Air pressure mattress applied to bed to relieve pressure, float heels while in bed with heel floater mat, floor nurses/wound NP (nurse practitioner) to perform wound care as ordered, monitor for healing, signs/symptoms of infection. Problem start date revised 10/6/16, pressure ulcer skin integrity: resident is at risk for skin breakdown related to incontinence, diagnosis of dementia, and the overall need for assistance with activities of daily living, turn and reposition every two hours and PRN, remove Hoyer sling from under resident when up in wheelchair and in bed. Do

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 _____	C 10/06/2016

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) COMPLETE DATE
2 565	Continued From page 5 not leave Hoyer sling under resident. Conduct a systematic skin inspection during daily cares. Pay particular attention to the bony prominences. Report concerns to nursing for prompt treatment. Keep clean and dry as possible. Minimize skin exposure to moisture. Provide incontinence care after each incontinent episode and use briefs to maintain personal hygiene and dignity when incontinent. On 10/5/16, at 7:08 a.m., R47 was observed to be in his room, dressed and sitting in his wheelchair with the Hoyer sling underneath him. At 7:55 a.m., R47 remained seated in his wheelchair with the Hoyer sling underneath him. At 8:41 a.m., R47 remained seated in his wheelchair in the dining room with the Hoyer sling underneath him and wellness coach (WC)-A was assisting R47 with eating. At 9:00 a.m., WC-A was observed to be pushing R47 in his wheelchair to the activity room, the Hoyer sling remained underneath R47. WC-A stated she had assisted R47 immediately after feeding him to the activity room. At 9:46 a.m., R47 remained seated in his wheelchair with the sling underneath him in the activity room. At 9:53 a.m., R47 was not in the activity room and WC-B stated she had assisted R47 from the activity room immediately to the chapel area for bible study. WC-B stated R47 had not been repositioned. At 9:53 a.m., WC-A confirmed R47 had not been repositioned when WC-A had assisted R47 from the dining room to the activity room. At 9:55 a.m., nursing assistant (NA)-F stated she had assisted NA-E to transfer R47 into his wheelchair after NA-E had dressed R47 during a.m. cares. NA-F confirmed she had not repositioned R47 since. NA-E confirmed she had completed a.m. cares for R47 and had stated the last time she had repositioned R47 had been after she had dressed R47 this morning. NA-E	2 565		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 565	Continued From page 6 confirmed she had not repositioned R47 since. At 9:58 a.m., WC-A was pushing R47 down the hallway towards his room and stated that was my fault they did not reposition R47 as I brought him to the wellness activity and then he went to bible study. On 10/5/16, at 12:04 p.m., NA-E confirmed the Hoyer sling was underneath R47 while R47 was seated in his wheelchair. NA-E stated as far as I know we always leave the sling underneath R47 when he is seated in his wheelchair, I have not been told different. On 10/06/16, at 10:24 a.m., registered nurse (RN)-B verified R47's care plan read the Hoyer sling was to be removed and the resident was to be off loaded every two hours. RN-B stated she would expect R47 to be repositioned every two hours and the Hoyer sling to be removed as care planned. On 10/06/16, at 3:42 p.m., the director of nursing stated she would expect the sling to be removed and the resident to be off loaded every two hours per the plan of care. A policy for following the care plan was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.	2 565		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 565	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for the use of an indwelling Foley catheter for 1 of 3 residents (R126) reviewed for urinary catheter use. Findings include: R126's current physician orders, included an order with the start date of 8/3/16, for change catheter monthly and as needed if occluded with 14 French catheter with 10 cc (cubic centimeters) balloon for disorder of urinary system, retention of urine and Foley catheter output every shift. R126's Treatment Administration Record dated from 9/6/16 to 10/6/16, indicated the Foley catheter was	2 570	Corrected	11/15/16

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 _____	C 10/06/2016

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) COMPLETE DATE
2 570	Continued From page 8 changed on the third day of each month and documented signatures for the catheter output every shift as ordered. On 10/4/16, at 9:16 a.m. R126 was observed to be seated in her wheelchair and had a urinary catheter drainage bag hanging underneath her wheelchair. During interview, on 10/4/16, at 10:25 a.m., registered nurse (RN)-B stated R126 had an indwelling Foley catheter and the reason for the catheter was disorder urinary system and urinary retention. R126's care plan problem start date 5/27/16, included problem: toileting/continence, limited in ability to toilet self-related to weakness. R126 is incontinent of bladder and bowel with interventions of assist with incontinence care if incontinent, inspect condition of perineal area after each incontinent episode, report any redness, rash, or broken area, use barrier cream as needed and provide extensive assistance for toileting. R126's care plan failed to be revised to include the use of an indwelling Foley catheter and interventions related to the catheter use. On 10/06/16, at 10:29 a.m., RN-B verified R126's care plan failed to identify R126 had in indwelling Foley catheter and interventions related to the catheter use. RN-A stated R126's indwelling Foley catheter was reinserted on 8/3/16. On 10/06/16, at 3:30 p.m., the director of nursing stated she would expect use of a Foley catheter to be care planned, which included reasons identified why the catheter was in use and interventions associated with the use of the catheter.	2 570		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 570	Continued From page 9 A policy for revision of care plan was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
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 document review the facility failed to identify and monitor	2 830	Corrected	11/15/16

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 _____	C 10/06/2016

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) COMPLETE DATE
2 830	Continued From page 10 bruising for 3 of 3 residents (R61, R92 and R129) reviewed for non-pressure related skin concerns. Findings Include: R61 was observed on 10/4/16, at 9:55 a.m., R61 had bruises to the top of her hands. R61's record did not reflect identification or monitoring of the bruises. R61's care plan dated 12/4/15 indicated problem: Resident bruises easily related to Plavix administered for history of Cerebral infarction and history of bruising. Approaches included: Nursing to continue to monitor for bruising, notify physician as needed. Measure and record description of bruise including, location, size, length and width, color, surrounding skin, presence/absence of pain, presence/absence of signs of healing. Monitor and record any complaints of pain, location, duration, quantity, quality, alleviating factors, aggravating factors. R61's progress notes were reviewed from 9/5/16 to 10/5/16 the documentation did not reflect identification or monitoring of the bruises. R61's bath sheet dated 10/4/16 indicated no skin concerns. On 10/05/2016, at 11:58 a.m. licensed practical nurse (LPN)-A verified through observation R61 to have bruising on the top of her left and right hands. LPN-A stated she would measure the bruises and implement monitoring for any swelling, pain and healing. LPN-A stated staff should monitor for bruises daily during cares. LPN-A verified the bruises were not documented on the bath sheet dated 10/4/16 and stated did not note the bruises on R61's hands during the skin inspection she completed on 10/4/16. LPN-A stated R61 bruised easily and stated she just documented on anything new she sees on the	2 830		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 830	Continued From page 11 resident on the bath sheets. LPN-A stated knows R61 bruises easily and we don't document on all of the bruises. R61's progress note dated 10/5/16 indicated, "Resident noted to have bruising to bilateral hands. Bruise to left hand purple in color measuring 7 cm [centimeter] x 3.5 cm. Skin intact. No swelling. Right hand bruise purple measuring 1.2 cm x 0.7 cm. Skin intact. No swelling. Resident denied pain r/t [related to] bruising. When asked how bruising happened, resident stated "I bruise so easy," "I probably bumped them again." Resident appears to be resting comfortably in recliner with call light accessible. Note left for NP [nurse practitioner]. Will continue to monitor." On 10/06/2016, at 10:01 a.m. nursing assistant (NA)-C stated she looked at resident's skin daily with cares, looking for any changes. NA-C stated she notified the nurse when she found any skin concerns during cares. NA-C stated on bath days the bath aide documented any skin concerns on the bath sheet and stated the nurse looked over the bath sheet and signed it. On 10/05/2016, at 12:52 a.m. the director of nurses (DON) stated if they are any new or unexplained bruises staff should notify the nurse and an event was created if there was an unexplained bruise. The DON stated staff should monitor skin for changes during personal cares and during baths and stated staff should document any skin changes, which included bruising. The DON stated if R61 had bath yesterday, she would have expected the bath sheets to have reflected the bruising to R61's hands. The DON stated the nursing assistants are to document on the bath sheets and the nurse is also to complete a skin check on bath days and should document any skin concerns	2 830		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 830	Continued From page 12 found on the bath day. The DON stated staff should follow the care plan for identifying and monitoring for bruises. A policy was requested for monitoring non-pressure related skin concerns and was not provided by the facility. R92 was observed on 10/04/16, at 10:18 a.m. R92 had a bruise located on her right hand between her middle finger and ring finger. R92's record did not reflect identification or monitoring of the bruise. On 10/06/16, at 11:21 a.m., during observation, registered nurse (RN)-B confirmed R92 had a bruise on located on her right hand between her middle finger and ring finger. RN-B confirmed R92's record lacked identification or monitoring of the bruise. RN-B stated the facility system was when a skin concern is noticed the nurse was to be informed. The nurse then would create an event in the computer system to monitor the bruising weekly until resolved. R92's care plan dated revised 6/6/16, indicated problem: at risk for skin breakdown related to needing assistance with cares, increased incontinence and increased weakness. Approaches included: conduct a systematic skin inspection during daily cares. Pay particular attention to the bony prominences. Report concerns to nursing for prompt treatment. Problem: receives anticoagulant therapy, at risk for bruising and bleeding. Approaches included observe for signs of active bleeding, protect from injury/trauma, administer medication as ordered, encourage to wear long sleeves if tolerable and monitor labs and vital signs. R92's progress notes were reviewed from 9/1/16 to 10/4/16 the documentation did not reflect	2 830		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 830	Continued From page 13 identification or monitoring of the bruise. On 10/06/16, at 3:43 p.m., the DON stated the staff were to notify the nurse regarding any change with skin on a daily basis, so the nurse can investigate further. R129 diagnosis found on the resident face sheet identifies unspecified atrial fibrillation. R129 has physician orders for Aspirin 81 mg daily and Coumadin 2 mg daily. Internal Medicine progress note dated 9/21/16, indicates R129 to have an International Normalized Ratio (INR) level of 1.7 with target INR range of 2 to 3. Coumadin (reduces clotting time) at that time was increased to 2.5 mg daily. Note indicates if any unusual bleeding or bruising develops that an appointment must be scheduled to recheck INR level. R129 was admitted to the facility on 9/15/16. A temporary care plan was put in place upon admission. Temporary care plan did not identify R129 ' s risk for bruising or bleeding related to physician ordered medications of Aspirin and Coumadin. Initial Nursing Body Audit form dated 9/15/16, indicates R129 to have bruising to the right forearm and left wrist. No measurements included. Weekly body audits form taken from the CNA (certified nursing assistant) book dated 9/16/16 and 10/4/16 indicates R129 to have no bruising with only a CNA signature. Weekly body audits provided to survey team on 10/6/16 after concerns were brought to facility attention indicates form to now have both a CNA and a licensed nursing staff's signature with bruise to left forearm/wrist identified. On 10/4/16, at 11:27 a.m. R129 was noted to have a large bruise to the top of the left forearm/wrist area. Reviewed progress notes and orders from	2 830		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 830	Continued From page 14 9/15/16 to 10/6/16. Bruise to top of left forearm/wrist was not identified or monitored. No order was present to monitor the bruise. Admission note does not indicate bruise to left forearm/wrist area. Interview on 10/5/16, at 7:47 a.m. with nursing assistant (NA)-D stated the bruise was old and had been present for a while. NA-D stated when she finds a bruise she reports to the nurse right away and has the nurse come in and look at it. Interview on 10/5/16, at 8:25 a.m. with licensed practical nurse (LPN)-B stated bruises are monitored weekly during the weekly shower. LPN-B stated R129's baths are on Tuesday mornings with the last bath taking place on 10/4/16. Weekly body audit from 10/4/16 indicated no bruising and identified, "all looked good." LPN-B stated he would measure the bruise. Progress note dated 10/5/16, at 2:43 p.m. identifies bruise to left forearm measures 5 cm x 5 cm. LPN-B did not enter an order for monitoring of the bruise until resolved. Interview on 10/6/16, at 11:30 a.m. with LPN-C and registered nurse (RN)-C stated R129's care plan did not include being at risk for bruising and stated that they would get it care planned. LPN-C and RN-C stated typically residents who are at risk for bruising their care plans reflect that. LPN-C and RN-C stated bruises are monitored weekly and that an aide and nurse complete the body audit sheet. When a bruise is identified the nurse will fill out an event on the bruise, determine how the bruise occurred and put in a nurse's order to monitor daily until it's resolved. LPN-C and RN-C also stated the weekly skin assessment should include the measurements of the bruise. Interview on 10/6/16, at 3:20 p.m. with RN-C stated R129's bruise was from an intravenous needle inserted and used at the hospital and was	2 830		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 830	Continued From page 15 there on admission. RN-C stated it was documented on the initial body audit form. RN-C stated that orders to monitor bruises aren't entered for bruises that are present on admission on new bruises that occur in the facility. Requested facility policy related to monitoring of skin conditions. Policy titled, "Resident Examination and Assessment" dated 02/2014, indicates, "the purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan" Policy identifies the need to assess for the, "presence of bruises, pressure sores, redness, edema, rashes." Policy identifies, "all assessment data obtained during the procedure" should be recorded in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to supervision and monitoring/documenting of non-pressure related skin concerns. The DON or designee, could provide training for all nursing staff related to non-pressure related skin concerns monitoring/documenting. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the	2 900		11/15/16

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 _____	C 10/06/2016

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) COMPLETE DATE
2 900	Continued From page 16 development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide every two hour turning and repositioning and removal of a Hoyer sling when seated in a wheelchair as directed by the comprehensive care plan for 1 of 3 residents (R47) identified at risk for pressure ulcers. Findings Include: R47's annual Minimum Data Set (MDS) dated 6/14/16, indicated R47 had severe cognitive impairment, required total assistance with transfers, was at risk for pressure ulcers, currently had one stage two pressure ulcer and one unstageable pressure ulcer. R47's care plan, revised 10/04/16, indicated problem pressure ulcers: resident has stage three pressure ulcer on left heel. Approaches included: administer scheduled pain medication as ordered to alleviate pain PRN (as needed), Dycem (non-slip pad) in wheelchair at all times, lamb's wool boots to BLE (bilateral lower extremities),	2 900	Corrected	

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 _____	C 10/06/2016

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) COMPLETE DATE
2 900	Continued From page 17 APM (anti-pressure mattress) applied to bed to relieve pressure, float heels while in bed with heel floater mat, floor nurses/wound NP (nurse practitioner) to perform wound care as ordered, monitor for healing, signs/symptoms of infection. Problem start date revised 10/6/16, pressure ulcer skin integrity: resident is at risk for skin breakdown related to incontinence, diagnosis of dementia, and the overall need for assistance with activities of daily living, turn and reposition every two hours and PRN, remove Hoyer sling from under resident when up in wheelchair and in bed. Do not leave Hoyer sling under resident. Conduct a systematic skin inspection during daily cares. Pay particular attention to the bony prominences. Report concerns to nursing for prompt treatment. Keep clean and dry as possible. Minimize skin exposure to moisture. Provide incontinence care after each incontinent episode and use briefs to maintain personal hygiene and dignity when incontinent. R47's Wound Summary Report dated 9/21/16, indicated pressure wound stage two to three right buttock wound: wound healed. On 10/5/16, at 7:08 a.m., R47 was observed to be in his room, dressed and sitting in his wheelchair with the Hoyer sling underneath him. At 7:55 a.m., R47 remained seated in his wheelchair with the Hoyer sling underneath him. At 8:41 a.m., R47 remained seated in his wheelchair in the dining room with the Hoyer sling underneath him and wellness coach (WC)-A was assisting R47 with eating. At 9:00 a.m., WC-A was observed to be pushing R47 in his wheelchair to the activity room, the Hoyer sling remained underneath R47. WC-A stated she had assisted R47 immediately after feeding him to the activity room. At 9:46 a.m., R47 remained seated	2 900		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 900	Continued From page 18 in his wheelchair with the sling underneath him in the activity room. At 9:53 a.m., R47 was not in the activity room and WC-B stated she had assisted R47 from the activity room immediately to the chapel area for bible study. WC-B stated R47 had not been repositioned. At 9:53 a.m., WC-A confirmed R47 had not been repositioned when WC-A had assisted R47 from the dining room to the activity room. At 9:55 a.m., nursing assistant (NA)-F stated she had assisted NA-E to transfer R47 into his wheelchair after NA-E had dressed R47 during a.m. cares. NA-F confirmed she had not repositioned R47 since. NA-E confirmed she had completed a.m. cares for R47 and had stated the last time she had repositioned R47 had been after she had dressed R47 this morning. NA-E confirmed she had not repositioned R47 since. At 9:58 a.m., WC-A was pushing R47 down the hallway towards his room and stated that was my fault they did not reposition R47 as I brought him to the wellness activity and then he went to bible study. On 10/5/16, at 12:04 p.m., NA-E confirmed the Hoyer sling was underneath R47 while R47 was seated in his wheelchair. NA-E stated as far as I know we always leave the sling underneath R47 when he is seated in his wheelchair, I have not been told differently. On 10/06/16, at 10:24 a.m., registered nurse (RN)-B verified R47's care plan read the sling was to be removed and the resident was to be off loaded every two hours. RN-B stated she would expect R47 to be repositioned every two hours and the sling to be removed as care planned. On 10/6/16, at 11;54 a.m., licensed practical nurse (LPN)-D stated R47 had prior pressure ulcers on his buttocks, but the areas healed a	2 900		

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 _____	C 10/06/2016

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) COMPLETE DATE
2 900	Continued From page 19 couple of weeks ago. On 10/06/16, at 3:42 p.m., the DON stated she would expect the sling to be removed and the resident to be off loaded every two hours per the plan of care. A policy for pressure ulcer skin conditions and following the care plan was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff responsible for giving cares/services on following the care plan exactly as assessed to promote healing and prevent pressure ulcers from developing. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section	21535		11/15/16

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 _____	C 10/06/2016

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) COMPLETE DATE
21535	Continued From page 20 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to identify specific mood symptoms to determine if an antidepressant was affective for depression for 1 of 5 residents (R103); failed to identify resident specific target behaviors for the use of an antipsychotic medication, complete a comprehensive sleep assessment and document physician justification for the use of melatonin (hormone) for sleep aide for 1 of 5 residents (R57) and failed to identify resident specific symptoms for use of an anti-anxiety medication to determine if it is affective, also attempt a tapering reduction or document a detailed physician justification as to why tapering was contraindicated at this time for the use of an antipsychotic and antidepressant medications for 1 of 5 residents (R72) reviewed for unnecessary medications. Findings include: R103 LACKED RESIDENT SPECIFIC MOOD SYMPTOMS TO DETERMINE IF ANTIDEPRESSANT WAS AFFECTIVE: R103's quarterly Minimum Data Set (MDS), dated 6/28/16, indicated R103 was cognitively intact,	21535	Corrected	

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 _____	C 10/06/2016

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) COMPLETE DATE
21535	Continued From page 21	21535		

had diagnoses of anxiety and depression, and moderately severe depression based on resident interview.
R103's care plan dated, 6/27/16 indicated Problem: Resident has long history of depression and anxiety and is treated with medications. Approaches included: Social Services will meet with resident quarterly, and as needed, to complete PHQ-9 Assessment (mental health status questionnaire) and provide supportive visit to assist in monitoring resident's mood. Will notify provider of significant concerns in changes in mood. Staff to encourage expression of needs and concerns. Listen and reassure as needed. Resident enjoys 1-1 visits.
R103's physician orders included the following orders: Zoloft (antidepressant) 100 mg (milligrams) twice a day dated 8/31/16. Wellbutrin XL (extended release antidepressant) 300 mg daily dated 6/30/16.

R103's progress notes were reviewed from 7/1/16 to 10/5/16 with no mood concerns identified.

On 10/06/2016, at 9:39 a.m. nursing assistant (NA)-A stated resident was very quiet and displayed very little emotion. NA-A stated R103 did not display any mood or behavioral concerns.

On 10/06/2016, at 2:00 p.m. nursing assistant (NA)-B stated she had not noticed any mood or behavior concerns for R103.

On 10/05/2016, at 9:41 a.m. registered nurse (RN)-B stated specific mood symptoms had not been identified for the use of the antidepressants for R103. RN-B stated staff monitor general mood symptoms and document any mood concerns in the progress notes.
RN-B stated the nurses put events into the

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 _____	C 10/06/2016

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) COMPLETE DATE
21535	Continued From page 22	21535		

electronic medical record when there is a medication added or changed and the nurses document each shift for a couple of weeks. RN-B stated if there were changes in mood or behavior during that time, the nurse notified the nurse practitioner for further review.

On 10/05/2016, at 12:43 p.m. the director of nurses (DON) stated mood symptoms should be identified and monitored for residents on antidepressants. The DON stated R103's care plan should have identified specific mood symptoms for monitoring. The DON stated by reviewing R103's care plan she was unable to determine what mood concerns R103 had. The DON stated R103's progress notes indicated she was pleasant, cooperative and orientated per her review.

On 10/06/2016, at 3:01 p.m. R103 stated her mood symptoms included being tearful and having crying episodes, feeling overwhelmed and stated she used to go to bed as an escape as life was very overwhelming. R103 stated her crying episodes have stopped after starting her medications.

A policy for identifying and monitoring mood symptoms for the use of antidepressants was requested and not provided by the facility.
R57 LACKED RESIDENT SPECIFIC TARGET BEHAVIORS IDENTIFIED FOR ANTIPSYCHOTIC MEDICATION:

R57's quarterly MDS, dated 8/4/16, indicated R57 was cognitively intact, had moderate symptoms of depression based on resident interview and had no behaviors.

R57's current physician orders included an order

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 _____	C 10/06/2016

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) COMPLETE DATE
21535	Continued From page 23 for risperidone (antipsychotic) 5 mg every bedtime for diagnosis of dementia with behavioral disturbances. R57's current care plan included problem: has diagnosis of major depression with approaches of administer medication as ordered, monitor mood every shift as ordered. Problem psychotropic drug use: at risk for adverse consequences related to receiving antidepressant medication for treatment of depression. Approaches: assess/record effectiveness of drug treatment. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Problem: appears to have a depressed mood/symptoms as indicated by scores obtained on PHQ-9 (depression scale). Social Services will meet with resident quarterly, and as needed, to complete PHQ-9 assessment and provide supportive visit to assist in monitoring resident's mood. Allow resident to have control over situations as possible. Convey an attitude of acceptance toward resident, listen and reassure as needed. Psychiatrist consult for depression and dementia presumed w/o (without) psychosis. Encourage resident to be involved with facility life. Encourage resident to continue with daily decision making as able to do so. Encourage verbalization of feelings. R57's care plan failed to identify specific target behaviors and interventions related to the use of an antipsychotic medication. On 10/06/16, at 11:00 a.m., RN-B reviewed R57's care plan and confirmed R57's care plan lacked specific target behaviors and interventions related to the use of the antipsychotic medication. On 10/06/16, at 3:45 p.m., the DON stated she would expect target behaviors to be identified and	21535		

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 _____	C 10/06/2016

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) COMPLETE DATE
21535	Continued From page 24 interventions implemented for the use of an antipsychotic medication. A policy for the use of antipsychotic medication was requested, but not provided. R57 LACKED COMPREHENSIVE SLEEP ASSESSMENT BEFORE STARTING HYPNOTIC; ONGOING MONITORING OF SLEEP FOR EFFECTIVENESS OF HYPNOTIC MEDICATION AND THE USE OF NON-PHARMACOLOGICAL INTERVENTIONS BEFORE GIVING HYPNOTIC FOR SLEEP R57's current physician orders included an order for melatonin 3 mg two hours prior to bedtime for diagnosis of insomnia, start date 5/5/16. R57's current care plan not dated, included, Problem: experiences insomnia/change in usual sleep pattern. Approaches: administer medications as ordered. Monitor and record effectiveness. Monitor and report any adverse side effects. Discourage daytime napping. Limit caffeine intake. Provide comfortable environment to promote sleep (clean bedding, comfortable bed clothing, incontinence care, comfortable temperature, ventilation). Reduce environmental disruptions (noise, staff disruptions, intercom, light). R57's physician progress notes dated 5/17/16 through 8/17/16, identified medications included melatonin 3 mg daily two hours prior to bedtime. On 10/06/16, at 11:00 a.m., RN-B was asked for a sleep assessment, non-pharmacological interventions used for sleep and monitoring melatonin for effectiveness for sleep. RN-B was unable to provide any of this information.	21535		

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 _____	C 10/06/2016

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) COMPLETE DATE
21535	Continued From page 25 On 10/06/16, at 3:45 p.m., the DON stated we monitor sleep habits three to five days after admission. The DON reviewed R57's record and stated I do not see any documentation in R57's record for non-pharmacological interventions attempted for sleep or documentation of sleep hours prior to starting the melatonin. A policy for sleep assessment was requested, but not provided. R72 LACKED RESIDENT SPECIFIC MOOD SYMPTOMS TO JUSTIFY THE USE AN ANTI-ANXIETY MEDICATION. JUSTIFICATION FOR STARTING AN ANTIDEPRESSANT MEDICATION AND LACK OF A GRADUAL DOSE REDUCTION (GDR) FOR USE OF AN ANTIPSYCHOTIC MEDICATION OR A COMPREHENSIVE PHYSICIANS JUSTIFICATION FOR NOT ATTEMPTING A GDR AT THIS TIME: R72's quarterly MDS, dated 8/9/16, indicated R72 severe cognitive impairment, had mild symptoms of depression based on resident interview, had no behaviors and received antipsychotic medication. R72's current physician orders included orders for Seroquel (antipsychotic) 25 mg twice daily (increased on 8/9/16) for dementia with behavioral disturbance and Cymbalta (antidepressant) 20 mg once daily for anxiety, start date of 9/20/16. R72's care plan dated 5/9/16, included behavioral symptoms problem: on antipsychotic (atypical) medication related to has socially inappropriate/disruptive behavioral symptoms due to cognitive deficit as evidenced by resident	21535		

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 _____	C 10/06/2016

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) COMPLETE DATE
21535	Continued From page 26	21535		

yelling at other residents at meal times, wandering, and yelling at staff. Approaches: Monitor resident for side effects related to use of antipsychotic medication. Nursing to administer Seroquel as ordered. Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Maintain a calm environment and approach to the resident. When resident begins to become socially inappropriate or disruptive, intervene and redirect resident in a calm manner.

R72's care plan failed to be revised to address the specific symptoms for diagnosis of anxiety and interventions related to the use of the Cymbalta medication.

On 10/6/16 at 11:20 a.m. RN-B was asked for information regarding the clinical rationale for starting Cymbalta and what mood behaviors are being monitored for effectiveness. Also the clinical rational for not attempting a GDR or the physicians comprehensive justification as to why it would be contraindicated at this time.

R72's physician progress notes lacked documented justification for the start of the Cymbalta medication and lacked documentation of physician justification for the increase in the Seroquel medication or at a minimum to include information as to why any attempted dose reduction for the Seroquel would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. RN-B was unable to provide this information.

On 10/06/16, at 3:36 p.m., the DON stated she would expect the physician to document the reason for the use of the Cymbalta medication

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 _____	C 10/06/2016

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) COMPLETE DATE
21535	Continued From page 27 and for the increase use of the Seroquel. The DON stated she would expect the care plan to be revised for the use of the Cymbalta and specific symptoms for anxiety to be identified. A policy for use of psychotropic medications and physician justification was requested, but not provided. SUGGESTED METHOD OF CORRECTION:The director of nursing (DON) or designee could develop systems to ensure resident medication regimens are thoroughly reviewed for unnecessary medications. The DON or designee could educate all appropriate staff on unnecessary medications. The DON or designee could develop a monitoring system to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21535		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and	21800		11/15/16

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 _____	C 10/06/2016

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) COMPLETE DATE
21800	Continued From page 28 shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of all Medicare Part A skilled services for 4 of 4 residents (R12, R2, R9 and R24) reviewed for liability notice and beneficiary appeal rights. Findings include: R12 was discharged from Medicare Part A on 8/12/16, and remained in the facility. R12 used 26 days of Medicare A coverage. The facility did not provide R12 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare.	21800	Corrected	

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 _____	C 10/06/2016

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) COMPLETE DATE
21800	Continued From page 29 R2 was discharged from Medicare Part A on 5/23/16, and remained in the facility until she discharged on 5/25/16. R2 used 35 days of Medicare A coverage. The facility did not provide R2 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R9 was discharged from Medicare Part A on 5/26/16, and remained in the facility. R9 used 39 days of Medicare A coverage. The facility did not provide R9 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R24 was discharged from Medicare Part A on 8/16/16, and remained in the facility. R24 used 40 days of Medicare A coverage. The facility did not provide R24 and/or his legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. During an interview on 10/06/2016 at 10:33 a.m. registered nurse (RN)-A stated the facility stopped providing the SNFABN to residents in the facility as they were told it was no longer required. RN-A stated it was brought to her attention through the survey process the SNFABN notices were required for residents that remained in the facility. RN-A stated she would re-implement the process immediately. The facility policy related to SNF (skilled nursing facility) DETERMINATION ON CONTINUED	21800		

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 _____	C 10/06/2016

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) COMPLETE DATE
21800	Continued From page 30 STAY was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21800		