DEPARTMENT OF HEAI	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAII	D CERTIFICA	TION A	AND TRANSMITTAL	ID: L3UF
	PART I -	TO BE COMPL	LETED BY TH	IE STAT	TE SURVEY AGENCY	Facility ID: 00644
1. MEDICARE/MEDICAID PROV NO.(L1) 245426	/IDER	3. NAME AND AD (L3) KODA LIVI	NG COMMUNI			4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICA (L2) 046492200	AID NO.	(L4) 2255 30TH S (L5) OWATONNA			(L6) 55060	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE ((L9) 11/01/2010	OF OWNERSHIP	7. PROVIDER/SU 01 Hospital		RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 18. ACCREDITATION STATUS:	1/28/2016 ^{L34)} (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct		10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Othe		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICAT	ION	10.THE FACILITY		S:		,
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re	quirements		2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
		1. Ad	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
12.Total Facility Beds	79 (L18)				5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	79 (L17)		liance with Program and/or Applied Wa		* Code: A *	(L12)
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY MEETS	
18 SNF 18/19 SN	NF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
79						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY RI 17. SURVEYOR SIGNATURE	×	Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
The Server on Sicilia Che		Dute .				
Brenda Fischer, Unit			6/2016	(L19)		, Enforcement Specialist 12/06/2016 (L20)
ł	PART II - TO BE	COMPLETED F	BY HCFA REG	HONAL	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGI	BILITY		PLIANCE WITH (ITS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible	to Participate				3. Both of the Above	
2. Facility is not Elig	ible (L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEME	ENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 02/01/1987	BEGINNINC	J DATE	ENDING DATE	1	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
(L27)	B. Rescind Su	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	0. INTERMEDIARY	CARRIER NO.		30. REMARKS	
	(7 2 2)	00450		(T. C. C)		
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	DATE	Posted 11/21/2016 Co.	
	(L32)			(L33)	DETERMINATION APP	ROVAL



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,

Kumalu 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



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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	SIT
	B. Wing	Y	(2	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).

ITE	М	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0156	Correction	ID Prefix F	F0280		Correction	ID Prefix	F0281		Correction
Reg. #	483.10(b)(5) - (483.10(b)(1)	10), Completed		83.20(d)(3 2)	3), 483.10(k)	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 F	F0309		Correction	ID Prefix	F0314		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. # 4	83.25		Completed	Reg. #	483.25(c)		Completed
LSC		11/15/2016				11/15/2016	LSC			11/15/2016
ID Prefix	F0329	Correction	ID Prefix F	F0441		Correction	ID Prefix			Correction
Reg. #	483.25(l)	Completed	4 Reg. #	83.65		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			
REVIEWI STATE A		REVIEWED BY (INITIALS)	DATE		SNATURE OF	SURVEYOR	10560		DATE	2/2016
REVIEWI CMS RO		BF/kfd REVIEWED BY (INITIALS)	12/6/201 DATE		ΊLE		10562		DATE	3/2016
FOLLOW 10/6/201		Y COMPLETED ON				CTED DEFICIEN ES (CMS-2567)		A SUMMARY OF HE FACILITY?		s 🗌 no

POST-CERTIFICATION REVISIT REPORT

				DATE OF REVI	SIT
	A. Building 02 - KODA LIVING COMMUNI ⁻ B. Wing	I Y		11/15/2016	
245426 _{Y1}	B. Willy		Y2	11/13/2010	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).

ITE	Μ	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	101	Completed	Reg. #	NFPA 101	Completed
LSC	K0011	11/15/2016	LSC K001	8	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		
REVIEW		REVIEWED BY (INITIALS) TL/kfd	DATE 12/06/2016	SIGNATURE OF	SURVEYOR	07000	DA	те 11/15/2016
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		37008	DA	
FOLLOW 10/5/201		Y COMPLETED ON		DR ANY UNCORREC]yes 🗌 no

DEPARTMENT OF HE	ALTH AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDIO	CAID SERVICES
					ND TRANSMITTAL		ID: L3UF
	PART I -	TO BE COMPL	ETED BY THE	STAT	'E SURVEY AGENCY		Facility ID: 00644
1. MEDICARE/MEDICAID PI NO.(L1) 245426	ROVIDER		DRESS OF FACILIT NG COMMUNITY			4. TYPE OF ACTIO	DN: <u>2(L8)</u> 2. Recertification
2. STATE VENDOR OR MED (L2) 046492200	ICAID NO.	(L4) 2255 30TH S (L5) OWATONNA			(L6) 55060	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANC (L9) 11/01/2010	GE OF OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGORY 05 HHA 09 I	ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 8. Full Survey Afte 	9. Other r Complaint
6. DATE OF SURVEY	10/06/2016 ^(L34)	02 SNF/NF/Dual	06 PRTF 10 1	NF	14 CORF		
8. ACCREDITATION STATUS	S:(L10)	03 SNF/NF/Distinct	07 X-Ray 11 I	ICF/IID	15 ASC	FISCAL YEAR END	ING DATE: (L35)
	TJC Other	04 SNF	08 OPT/SP 12 I	RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFIC	CATION	10.THE FACILITY	IS CERTIFIED AS:				
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of		
To (b):		Program Re Compliance	•		2. Technical Personnel	6. Scope of S	
		-			3. 24 Hour RN	7. Medical D	
12. Total Facility Beds	79 (L18)	1. Ad	cceptable POC		4. 7-Day RN (Rural SN	_	
13.Total Certified Beds	79 (L17)	X B. Not in Com	pliance with Program		5. Life Safety Code	9. Beds/Room	1
		Requirements	and/or Applied Waive	ers:	* Code: B *	(L12)	
14. LTC CERTIFIED BED BRE	EAKDOWN				15. FACILITY MEETS		
18 SNF 18/19	9 SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
,	79						
(L37) (L3	38) (L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Sarah Strenke, HF			`	L19)	Kamala Fiske-Downing,		cialist 11/18/2016 (L20)
	PART II - TO BE	COMPLETED B	BY HCFA REGIO	ONAL	OFFICE OR SINGLE S	TATE AGENCY	_
19. DETERMINATION OF EL			PLIANCE WITH CIV TS ACT:	/IL		ol Interest Disclosure Stmt	
1. Facility is Eligi	-				3. Both of the Above	:	
2. Facility is not	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEMENT	Г	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION 02/01/1987	BEGINNING	G DATE	ENDING DATE		VOLUNTARY 00 01-Merger, Closure 0		<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provid	ler Status Change
(L2	27)		(L44)			00-Active	•
(L2	B. Rescind St	uspension Date:	(1.45)				
28. TERMINATION DATE:	20	9. INTERMEDIARY/	(L45)		30. REMARKS		
Index and the product of the pr	27	00450					
	(L28)	00430	(L	.31)			
					Dested 11/21/2016 C		
31. RO RECEIPT OF CMS-153		2. DETERMINATION	OF APPKUVAL DAT	_	Posted 11/21/2016 Co.		
	(L32)		(L	_33)	DETERMINATION APPE	ROVAL	



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 <u>Email: gary.nederhoff@state.mn.us</u> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

Enclosure

cc: Licensing and Certification File

		AND HUMAN SERVICES & MEDICAID SERVICES		· ·	FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245426	B. WING		10/	06/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW		
KODA LI	VING COMMUNITY			OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 000)		
F 156 SS=E	as your allegation of Department's accep enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa regulations has bee your verification. "A recertification su complaint investiga the time of the stan An investigation of completed and four 483.10(b)(5) - (10), RIGHTS, RULES, S The facility must inf and in writing in a la understands of his regulations governi responsibilities duri facility must also pr notice (if any) of the §1919(e)(6) of the A made prior to or up resident's stay. Re any amendments to writing.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with rvey was conducted and tion(s) were also completed at	F 156	5		11/15/16
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically 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.

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		AND HUMAN SERVICES			FORM	: 11/09/2016 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245426	B. WING		10/	06/2016	
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
KODA LI	VING COMMUNITY			255 30TH STREET NW DWATONNA, MN 55060			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 156	entitled to Medicaid of admission to the resident becomes of items and services facility services und which the resident r other items and services inform each resider the amount of charg inform each resider the items and servic (i)(A) and (B) of this The facility must inf at the time of admis the resident's stay, facility and of charg including any charg under Medicare or I The facility must fur legal rights which in A description of the for establishing elig the right to request 1924(c) which dete non-exempt resour- institutionalization a spouse an equitable cannot be consider toward the cost of t medical care in his down to Medicaid e	I benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing der the State plan and for may not be charged; those rvices that the facility offers esident may be charged, and ges for those services; and nt when changes are made to ces specified in paragraphs (5) is section. Form each resident before, or ssion, and periodically during of services available in the ges for those services, les for services not covered by the facility's per diem rate. Frnish a written description of ncludes: manner of protecting personal raph (c) of this section; requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending	F 156				

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		AND HUMAN SERVICES				FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245426	B. WING			10/	06/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KODA LI	VING COMMUNITY				255 30TH STREET NW DWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 156	groups such as the agency, the State li ombudsman progra advocacy network, unit; and a stateme complaint with the S agency concerning misappropriation of facility, and non-cor directives requirem The facility must inf name, specialty, an physician responsite The facility must pro- written information, applicants for admis- information about h Medicare and Medi	nent State client advocacy State survey and certification censure office, the State am, the protection and and the Medicaid fraud control nt that the resident may file a State survey and certification resident abuse, neglect, and resident property in the mpliance with the advance	F ·	156			
	by: Based on interview facility failed to prov Nursing Facility Adv (SNFABN) upon ter A skilled services for R9 and R24) review beneficiary appeal in Findings include:	NT is not met as evidenced v and document review, the vide the required Skilled vanced Beneficiary Notice rmination of all Medicare Part or 4 of 4 residents (R12, R2, ved for liability notice and rights. d from Medicare Part A on			Resident R12, R2, and R24 no lo reside in facility. All residents in wi Medicare part A ends and the resi remains in the facility are issued S along with Medicare denials accor CMS guidelines. All residents who discharge part A and remain in fac be audited for compliance. CMS guidelines will be followed. MDS coordinator educated on requirem SNFABN. Results of audits will be	hich dent NFABN ding to ility will	

Facility ID: 00644

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245426	B. WING		10/(06/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA L	IVING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	8/12/16, and remain days of Medicare A provide R12 and/or SNFABN/Centers for Services (CMS)-10 liability for non-cover to appeal the denia R2 was discharged 5/23/16, and remain discharged on 5/25 Medicare A coverage R2 and/or her legal SNFABN/Centers for Services (CMS)-10 liability for non-cover to appeal the denia R9 was discharged 5/26/16, and remain days of Medicare A provide R9 and/or for SNFABN/Centers for Services (CMS)-10 liability for non-cover to appeal the denia R24 was discharge 8/16/16, and remain days of Medicare A provide R24 and/or SNFABN/Centers for Services (CMS)-10 liability for non-cover to appeal the denia R24 was discharge 8/16/16, and remain days of Medicare A provide R24 and/or SNFABN/Centers for Services (CMS)-10 liability for non-cover to appeal the denia	ned in the facility. R12 used 26 a coverage. The facility did not r her legal representative with a or Medicare and Medicaid 0055 to inform her of potential ered services and of her right at to Medicare. A from Medicare Part A on ned in the facility until she 5/16. R2 used 35 days of ge. The facility did not provide I representative with a or Medicare and Medicaid 0055 to inform her of potential ered services and of her right at to Medicare. A from Medicare Part A on ned in the facility. R9 used 39 a coverage. The facility did not her legal representative with a or Medicare and Medicaid 0055 to inform her of potential ered services and of her right at to Medicare Part A on ned in the facility. R9 used 39 a coverage. The facility did not her legal representative with a or Medicare.	F 156			

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE	E SURVEY PLETED
		245426	B. WING			10/0	06/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY				255 30TH STREET NW WATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 156 F 280 SS=D	RN-A stated it was through the survey were required for re- facility. RN-A stated process immediate The facility policy re- facility) DETERMIN STAY was requested 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in plannic changes in care and A comprehensive cs interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	e told it was no longer required. brought to her attention process the SNFABN notices esidents that remained in the d she would re-implement the ly. elated to SNF (skilled nursing ATION ON CONTINUED ed but not provided. 0(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ng care and treatment or		280			11/15/16
	by:	NT is not met as evidenced ion, interview and document			R126's care plan has been updated	and	

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	T OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	· /	PLETED
		245426	B. WING		10/	06/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA L	IVING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 280	review, the facility fithe use of an indweresidents (R126) reuse. Findings include: R126's current physorder with the start change catheter modes occluded with 14 Fit (cubic centimeters) system, retention or output every shift. FAdministration Recc 10/6/16, indicated t changed on the thir documented signate every shift as order On 10/4/16, at 9:16 be seated in her whe catheter drainage be wheelchair. During interview, or registered nurse (Rindwelling Foley cate catheter was disord retention. R126's care plan princluded problem: t ability to toilet self-rincontinent of bladd interventions of assistered nurse of a set of the seated of the set of the self-rincontinent of bladd interventions of assistered nurse of the seated of the set of the self-rincontinent of bladd interventions of assistered nurse of the seated of the self-rincontinent of bladd interventions of assistered nurse of the seated of the	ailed to revise the care plan for elling Foley catheter for 1 of 3 eviewed for urinary catheter sician orders, included an date of 8/3/16, for onthly and as needed if rench catheter with 10 cc balloon for disorder of urinary f urine and Foley catheter R126's Treatment ord dated from 9/6/16 to he Foley catheter was rd day of each month and ures for the catheter output ed. a.m. R126 was observed to neelchair and had a urinary wag hanging underneath her n 10/4/16, at 10:25 a.m., N)-B stated R126 had an theter and the reason for the fer urinary system and urinary roblem start date 5/27/16, oileting/continence, limited in related to weakness. R126 is	F 280	 reviewed on Nov 8th, 2016. All care plans including cathete areas will be audited for accura corrected by Nov 15, 2016. The facility will identify other re- requiring the nurse managers t Matrix Facility Activity report for Orders daily Mon-Friday and So be ran on Monday. This report new orders for each resident at to the nurse as to significant ch and/or care plans needs for eac on their unit. Systemic change will occur as Activity Report will be required manage and will be mandatory ongoing manner. D.O.N. to audit each managers Activity Reports for completion through on the care plan weekl month and monthly for 2 month Results of audit will be reported monthly Quality council meeting the designee will provide data f Council. Licensed staff will be educated importance of care plans and th comprehensive goals and obje- well as the requirement to utiliz Facility Activity Report by Nov 1 	sidents by o run the New at-Mon to will list all nd will cue anges ch resident the Facility as a tool to utilized an Facility and follow y for one s. I at the g. DON or or Quality on the ne need for ctives as e the	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245426	B. WING			10/06/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY				255 30TH STREET NW WATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 F 281 SS=D	as needed and prov toileting. R126's car include the use of a and interventions re On 10/06/16, at 10:: care plan failed to ic Foley catheter and ic catheter use. RN-A Foley catheter was On 10/06/16, at 3:3 stated she would ex to be care planned, identified why the ca interventions assoc catheter. A policy for revision but not provided. 483.20(k)(3)(i) SER PROFESSIONAL S The services provid must meet profession by: Based on interview failed to ensure a te developed following comprehensive carr included high risk for residents (R129) du Findings include:	 vide extensive assistance for re plan failed to be revised to an indwelling Foley catheter elated to the catheter use. 29 a.m., RN-B verified R126's dentify R126 had in indwelling interventions related to the stated R126's indwelling reinserted on 8/3/16. 0 p.m., the director of nursing quect use of a Foley catheter which included reasons atheter was in use and iated with the use of the of care plan was requested, VICES PROVIDED MEET STANDARDS led or arranged by the facility onal standards of quality. NT is not met as evidenced and record review, facility emporary care plan had been g admission and before the e plan is developed to have or bleeding/bruising for 1 of 3 ue to use of a blood thinner. 	F 2		R129 skin risk assessment was completed on 9/15/2016. Temporary plan will be revised to include bleeding/bruising risk factors by 11/15/2016. New admission tempora care plans will include bleeding/bruis risk factors. This will allow staff to ide those at risk. Initial body audit will ide bruising present upon admission. W	y care ary sing lentify entify	11/15/16

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	-	AND HUMAN SERVICES	r		0		APPROVEI 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	· · /	E SURVEY PLETED		
		245426	B. WING			10/0	06/2016		
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
KODA L	VING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE		
F 281	and Coumadin 2 m Internal Medicine p indicates R129 to h target INR (internat of 2 to 3. Coumadir 2.5 mg daily. Note i bleeding or bruising appointment must b level. R129 was admitted temporary care plan admission. Tempor R129's risk for bruis physician ordered r Coumadin. Interview on 10/6/10 practical nurse (LPI (RN)-C stated R129 include being at rist they would get it ca stated typically resid bruising their care p RN-C stated bruise that an aide and nu sheet. When a brui out an event on the bruise occurred and monitor daily until it also stated the wee include the measur Care plan dated 10 surveyor inquiring b the facility and it ide anticoagulant thera fibrillation and is at Care plan identifies	n orders for Aspirin 81 mg daily g daily. rogress note dated 9/21/16, ave an INR level of 1.7 with ional normalized ratio) range n at that time was increased to ndicates if any unusual		281	body audits will monitor status of b Admission nurse and bridge nurses educated on identifying bruising/ble risk factors by 11/15/2016. MDS Coordinator will audit for compliand during time of admission MDS. Res audits will be reported at quality co DON or designee will provide data	s will be eding ce sults of uncil.			

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI			0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G	()	PLETED
		245426	B. WING		10/	06/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 281	Continued From pa	ige 8	F 28	1		
		are plans does not include to the initial plan of care.				
F 282 SS=D		RVICES BY QUALIFIED	F 28	2		11/15/16
	must be provided b	led or arranged by the facility y qualified persons in Ich resident's written plan of				
	by: Based on observat review, the facility f identifying and mor residents (R61) rev skin concerns and for interventions for conditions for 1 of 3 pressure ulcers. Findings Include:	NT is not met as evidenced tion, interview and document ailed to follow the care plan for nitoring bruises for 1 of 3 iewed for non-pressure related failed to follow the care plan pressure related skin 8 residents (R47) reviewed for		R61 and R47 had their care plans reviewed. Care plans will be revise needed. Skin risk assessments rev for both residents. Weekly body au be used by nursing staff as a tool t identify new and monitor existing s integrity issues. All care plans inclu- skin risk problem areas will be revi- for accuracy quarterly per MDS sc Review of POC (Point of Care prof-	ed as viewed udits will o kin uding ewed hedule. iile) for	
	indicated problem: to Plavix administer infarction and histo included: Nursing to bruising, notify physi and record descript length and width, co presence/absence signs of healing. Mo complaints of pain: quality, alleviating f R61 was observed	ive care plan dated 12/4/15 Resident bruises easily related red for history of Cerebral ry of bruising. Approaches o continue to monitor for sician as needed. Measure tion of bruise (location, size, olor, surrounding skin, of pain, presence/absence of onitor and record any location, duration, quantity, actors, aggravating factors. on 10/4/16, at 9:55 a.m., R61 op of her hands. R61's record		care plan interventions will be prov direct care staff by 11/15/2016. Ra sling placement compliance audits completed biweekly for 4 weeks to monitor compliance. Results of au be reported at quality council. DON designee will provide data for QC.	ndom will be dits will	

Facility ID: 00644

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 11/09/2016 APPROVED 0938-0391				
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		245426	B. WING		10/	06/2016				
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
KODA LI	IVING COMMUNITY			2255 30TH STREET NW DWATONNA, MN 55060						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE				
F 282	did not reflect ident bruises. On 10/05/2016, at 7 nurse (LPN)-A verif to have bruising on hands. LPN-A state bruises and implem swelling, pain and h should monitor for h LPN-A verified the h on the bath sheet d not note the bruises skin inspection she stated R61 bruised documented on any resident on the bath bruises easily and v bruises. On 10/05/2016, at 7 nurses (DON) state unexplained bruises and an event was of unexplained bruises monitor skin for cha and during baths ar document any skin bruising. The DON yesterday, she wou sheets to have refle hands. The DON st are to document on nurse is also to con days and should do found on the bath d expected staff to fo identifying and mon	ification or monitoring of the 11:58 a.m. licensed practical fied through observation R61 the top of her left and right ad she would measure the nent monitoring for any healing. LPN-A stated staff bruises daily during cares. bruises were not documented dated 10/4/16 and stated did s on R61's hands during the completed on 10/4/16. LPN-A easily and stated she just ything new she sees on the h sheets. LPN-A stated R61 we don't document on all of the 12:52 a.m. the director of ed if there are any new or s staff should notify the nurse created if there was an . The DON stated staff should anges during personal cares nd stated staff should changes, which included stated if R61 had bath and have expected the bath ected the bruising to R61's tated the nursing assistants in the bath sheets and the mplete a skin check on bath ocument any skin concerns day. The DON stated she ollow the care plan for	F 282							

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245426 B. WING 10/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW KODA LIVING COMMUNITY OWATONNA, MN 55060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 10 F 282 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 11/09/2016

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/09/2016 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245426	B. WING	i		10/06/2016			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
KODA LI	VING COMMUNITY				255 30TH STREET NW DWATONNA, MN 55060				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 282	Continued From pa	ge 11	F	282					
	be in his room, dres wheelchair with the At 7:55 a.m., R47 r wheelchair with the At 8:41 a.m., R47 r wheelchair in the di underneath him and assisting R47 with d was observed to be wheelchair to the ad remained underneat assisted R47 imme activity room. At 9:2 in his wheelchair wit the activity room. At 9:2 in his wheelchair wit the activity room and W R47 from the activit chapel area for bibl not been reposition confirmed R47 had WC-A had assisted the activity room. A (NA)-F stated she f R47 into his wheelc R47 during a.m. ca not repositioned R4 had completed a.m the last time she had after she had dress confirmed she had 9:58 a.m., WC-A w hallway towards his fault they did not re to the wellness acti study.	a.m., R47 was observed to seed and sitting in his Hoyer sling underneath him. emained seated in his Hoyer sling underneath him. emained seated in his ning room with the Hoyer sling d wellness coach (WC)-A was eating. At 9:00 a.m., WC-A e pushing R47 in his ctivity room, the Hoyer sling th R47. WC-A stated she had diately after feeding him to the 46 a.m., R47 remained seated th the sling underneath him in t 9:53 a.m., R47 was not in the /C-B stated she had assisted ty room immediately to the e study. WC-B stated R47 had ed. At 9:53 a.m., WC-A not been repositioned when R47 from the dining room to t 9:55 a.m., nursing assistant had assisted NA-E to transfer thair after NA-E had dressed res. NA-F confirmed she had 7 since. NA-E confirmed she . cares for R47 and had stated d repositioned R47 had been ed R47 this morning. NA-E not repositioned R47 since. At as pushing R47 down the room and stated that was my position R47 as I brought him vity and then he went to bible							

Facility ID: 00644

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245426 B. WING 10/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW KODA LIVING COMMUNITY OWATONNA, MN 55060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 12 F 282 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 Hover 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. 483.25 PROVIDE CARE/SERVICES FOR F 309 F 309 11/15/16 HIGHEST WELL BEING SS=D 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 R61, R92, and R129 had their skin risk review the facility failed to identify and monitor assessments reviewed. Assessments will bruising for 3 of 3 residents (R61, R92 and R129) be revised as needed. Weekly body audits

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		& MEDICAID SERVICES				0938-039
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245426	B. WING _		10/	06/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA L	IVING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 309	reviewed for non-pr Findings Include: R61 was observed had bruises to the t did not reflect ident bruises. R61's care plan dat Resident bruises ea administered for his history of bruising. to continue to moni physician as needed description of bruis length and width, ca presence/absence signs of healing. Ma complaints of pain, quality, alleviating fr R61's progress not to 10/5/16 the docu identification or mo R61's bath sheet da concerns. On 10/05/2016, at nurse (LPN)-A verifi to have bruising on hands. LPN-A state bruises and implem swelling, pain and h should monitor for I LPN-A verified the I on the bath sheet do not note the bruises skin inspection she	on 10/4/16, at 9:55 a.m., R61 op of her hands. R61's record ification or monitoring of the ted 12/4/15 indicated problem: asily related to Plavix story of Cerebral infarction and Approaches included: Nursing tor for bruising, notify d. Measure and record e inlcuding, location, size, olor, surrounding skin, of pain, presence/absence of onitor and record any location, duration, quantity, actors, aggravating factors. es were reviewed from 9/5/16 imentation did not reflect nitoring of the bruises. ated 10/4/16 indicated no skin 11:58 a.m. licensed practical ied through observation R61 the top of her left and right ed she would measure the nent monitoring for any nealing. LPN-A stated staff bruises daily during cares. bruises were not documented lated 10/4/16 and stated did s on R61's hands during the completed on 10/4/16. LPN-A easily and stated she just	F 30	9 will be used by nursing staff as a tidentify new and monitor existing integrity issues. Resident examina assessment policy will be reviewe nursing staff by 11/15/2016. Weel audit tool will be audited randomly weekly for 4 weeks to ensure com Results of audits will be reported a council. DON or designee will prodata for QC.	skin ation and d with dy body twice pliance. at quality	

		AND HUMAN SERVICES				FORM	: 11/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		245426	B. WING	i		10/	06/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	IVING COMMUNITY				2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	resident on the bath R61 bruises easily of the bruises. R61's progress note "Resident noted to hands. Bruise to lef measuring 7 cm [ce intact. No swelling. measuring 1.2 cm of swelling. Resident of bruising. When ask resident stated "I br bumped them again resting comfortably accessible. Note lef Will continue to mo On 10/06/2016, at 1 (NA)-C stated she I with cares, looking she notified the nur concerns during ca the bath aide docur the bath sheet and the bath sheet and On 10/05/2016, at 1 nurses (DON) state unexplained bruises and an event was c unexplained bruises and during baths ar document any skin bruising. The DON yesterday, she wou sheets to have refle hands. The DON st are to document on	h sheets. LPN-A stated knows and we don't document on all e dated 10/5/16 indicated, have bruising to bilateral ft hand purple in color entimeter] x 3.5 cm. Skin Right hand bruise purple x 0.7 cm. Skin intact. No denied pain r/t [related to] ked how bruising happened, ruise so easy," "I probably n." Resident appears to be in recliner with call light ft for NP [nurse practitioner]. mitor." 10:01 a.m. nursing assistant looked at resident's skin daily for any changes. NA-C stated rse when she found any skin res. NA-C stated on bath days mented any skin concerns on stated the nurse looked over	F	309			

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			0	FORM. MB NO.	11/09/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		.E CONSTRUCTION		E SURVEY PLETED
		245426	B. WING			10/0	06/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY				255 30TH STREET NW DWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	days and should do found on the bath d should follow the ca monitoring for bruis A policy was reques non-pressure relate provided by the faci R92 was observed R92 had a bruise lo between her middle record did not reflec of the bruise. On 10/06/16, at 11: registered nurse (R bruise on located of middle finger and ri R92's record lacked the bruise. RN-B sta when a skin concer be informed. The m event in the comput bruising weekly unt R92's care plan dat problem: at risk for needing assistance incontinence and in Approaches include inspection during da attention to the bon concerns to nursing Problem: receives a for bruising and ble observe for signs of	 becument any skin concerns lay. The DON stated staff are plan for identifying and les. beted for monitoring ed skin concerns and was not ility. con 10/04/16, at 10:18 a.m. becated on her right hand e finger and ring finger. R92's et identification or monitoring 21 a.m., during observation, IN)-B confirmed R92 had a n her right hand between her ng finger. RN-B confirmed d identification or monitoring of ated the facility system was in is noticed the nurse was to urse then would create an ter system to monitor the il resolved. bed revised 6/6/16, indicated skin breakdown related to with cares, increased 	F	309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245426 B. WING 10/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW KODA LIVING COMMUNITY OWATONNA, MN 55060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245426 B. WING 10/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW KODA LIVING COMMUNITY OWATONNA, MN 55060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 309 Continued From page 17 F 309 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.

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		AND HUMAN SERVICES				FORM	11/09/2016 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245426	B. WING			10/	06/2016		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
KODA LI	VING COMMUNITY				2255 30TH STREET NW DWATONNA, MN 55060				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 309 F 314 SS=D	LPN-C and RN-C a assessment should the bruise. Interview on 10/6/10 stated R129's bruis needle inserted and there on admission documented on the stated that orders to entered for bruises on new bruises that Requested facility p skin conditions. Pol Examination and As indicates, "the purp examine and asses abnormalities in her basis for the care p to assess for the, "p sores, redness, ede "all assessment dat procedure" should b medical record. 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop p individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores	Iso stated the weekly skin include the measurements of 6, at 3:20 p.m. with RN-C e was from an intravenous d used at the hospital and was . RN-C stated it was initial body audit form. RN-C o monitor bruises aren't that are present on admission t occur in the facility. policy related to monitoring of icy titled, "Resident ssessment" dated 02/2014, ose of this procedure is to as the resident for any alth status, which provides a lan" Policy identifies the need presence of bruises, pressure ema, rashes." Policy identifies, ta obtained during the be recorded in the resident's ENT/SVCS TO RESSURE SORES prehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that uble; and a resident having eives necessary treatment and e healing, prevent infection and		309			11/15/16		

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	0938-039
	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING		COMPLETED	
		245426	B. WING			10/0	06/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY		2255 30TH STREET NW OWATONNA, MN 55060				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 314	Continued From pa	ge 19	F 3	314			
	by: Based on observat review, the facility fa turning and repositi sling when seated i the comprehensive (R47) identified at r Findings Include: R47's annual Minim 6/14/16, indicated F impairment, require transfers, was at ris currently had one s one unstageable pr R47's care plan, rev problem pressure up pressure ulcer on le administer schedule to alleviate pain PR (non-slip pad) in wh wool boots to BLE (APM (anti-pressure relieve pressure, flo floater mat, floor nu practitioner) to perfer monitor for healing, Problem start date ulcer skin integrity: breakdown related dementia, and the o with activities of dai every two hours and from under resident bed. Do not leave H Conduct a systema	tion, interview and document ailed to provide every two hour oning and removal of a Hoyer n a wheelchair as directed by care plan for 1 of 3 residents isk for pressure ulcers.			R47's skin risk assessment will be reviewed and updated by 11/15/201 R 47's care plan will be reviewed and updated by 11/15/2016. R 47's weekly skin assessment will updated by 11/11/2016 All residents that need mechanical be individually assessed for risk and benefits associated with potential s shear as it relates to removal of the sling while the resident is in the wheelchair by 11/15/16. The weekly skin assessment will be revised to include assessment of the for risk /benefit of shearing. This assessment will be individualized a based upon the residents' ability to reposition and the additional risk associated with skin shearing. The assessment will be turned into the manager and the care plan updated accordingly. Random audits of wheelchair positi as it relates to placement of the hos sling will occur weekly for four week times per month for one month, mo for one month and as needed there. The audit will include review of the plan for follow through when indica Education of all staff will occur by 11/15/2016 as to the importance of following care plan, providing an individualized assessment as it relate placement of the hoyer lift sling and for skin shearing within the wheelch DON to bring results of audits to the monthly quality council meeting.	nd be lifts will d kin e lift e skin nd skin d oning ver lift (s, two onthly eafter. care ted. ttes to d risk hair.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245426 B. WING 10/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW KODA LIVING COMMUNITY OWATONNA, MN 55060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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 Hover 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

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/09/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245426	B. WING		10/	06/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
KODA LI	VING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 314	after she had dress confirmed she had 9:58 a.m., WC-A wa hallway towards his fault they did not re- to the wellness activistudy. On 10/5/16, at 12:0 Hoyer sling was und seated in his wheel- know we always lead when he is seated i been told differently On 10/06/16, at 10: (RN)-B verified R47 was to be removed loaded every two he expect R47 to be re- and the sling to be in On 10/6/16, at 11;5- nurse (LPN)-D state ulcers on his buttoc couple of weeks ag On 10/06/16, at 3:4 would expect the sl resident to be off lo plan of care. A policy for pressur- following the care p provided.	d repositioned R47 had been ed R47 this morning. NA-E not repositioned R47 since. At as pushing R47 down the room and stated that was my position R47 as I brought him vity and then he went to bible 4 p.m., NA-E confirmed the derneath R47 while R47 was chair. NA-E stated as far as I ave the sling underneath R47 n his wheelchair, I have not 7. 24 a.m., registered nurse 7's care plan read the sling and the resident was to be off purs. RN-B stated she would epositioned every two hours removed as care planned. 4 a.m., licensed practical ed R47 had prior pressure ks, but the areas healed a o. 2 p.m., the DON stated she ing to be removed and the aded every two hours per the e ulcer skin conditions and lan was requested, but not	F 314			11/15/16
F 329 SS=D	483.25(I) DRUG RE UNNECESSARY D	EGIMEN IS FREE FROM RUGS	F 329			11/15/16

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		AND HUMAN SERVICES			FORM): 11/09/2016 1 APPROVED). 0938-0391			
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT	TE SURVEY MPLETED			
		245426	B. WING		10	/06/2016			
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
KODA LI	VING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 329	Continued From pa	lge 22	F3	329					
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessal as diagnosed and o record; and resider drugs receive gradu behavioral interven	Ig regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above. The ensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical the who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these							
	by: Based on interview facility failed to iden to determine if an a for depression for 1 to identify resident the use of an antips a comprehensive s document physician melatonin (hormon	NT is not met as evidenced y and document review the ntify specific mood symptoms intidepressant was affective of 5 residents (R103); failed specific target behaviors for sychotic medication, complete leep assessment and n justification for the use of e) for sleep aide for 1 of 5 d failed to identify resident			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	8			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426		(X2) MULTIPLE CONSTRUCTION		(X3) DATE	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED	
		B. WING		10/06/2016		
NAME OF F	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 329		-	F 32			
	 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. 			medications will have target beh identified on care plan and in EI 11/15/2016. Licensed staff will e to document target behaviors w EMAR by 11/15/2016. Target be and sleep log compliance will be quarterly according to MDS sch Results of audits will be reporte council. DON or designee will p data for QC. Addendum: R72's MD was updated on 8/9/2 physician reviewed behaviors a identified that the she needed to her Seroquel because of behav were escalating. New orders w obtained on 8/9/2016. Because resident was changed in orders reduction was not done due to r target behaviors. It was also no Dr. Wallner reviewed resident's care, and stated that she on 9/2 was going to start Cymbalta as continuation of the medications. Other residents with drugs such antidepressants, antianxiety, an and hypnotic medication will hav behaviors identified on the TAR	AR by ducated thin havior e audited edule. d at quality rovide 2016 the nd increase ors that ere this the dose esident's ng such esidents. effect the ted that plan of 3/16 she well as as tipsychotic ve target	
	R103's physician or orders: Zoloft (antic (milligrams) twice a	ders included the following lepressant) 100 mg day dated 8/31/16. Wellbutrin se antidepressant) 300 mg		November 15th, 2016. Random audits for completion of behaviors & dose reductions will completed by the Unit Manager for one month, two times per mone one month and monthly for one Random audits will occur on an	l be s weekly onth for month.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245426 B. WING 10/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW KODA LIVING COMMUNITY OWATONNA, MN 55060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 24 F 329 to 10/5/16 with no mood concerns identified. provided to the DON for review and reported to the quality council monthly. On 10/06/2016, at 9:39 a.m. nursing assistant GDR's will be reviewed guarterly with the (NA)-A stated resident was very guiet and primary physician(s) and noted displayed very little emotion. NA-A stated R103 accordingly within the medical record did not display any mood or behavioral concerns. progress notes. 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

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PRINTED: 11/09/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES				FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245426	B. WING			10/(06/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY				2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	having crying episo stated she used to y was very overwhelm episodes have stop medications. A policy for identifyi symptoms for the u requested and not p R57 LACKED RES BEHAVIORS IDEN ANTIPSYCHOTIC I R57's quarterly MD was cognitively inta depression based on behaviors. R57's current physi for risperidone (anti bedtime for diagnos disturbances. R57's current care p diagnosis of major of administer medicati every shift as order use: at risk for adver receiving antidepres of depression. Appr effectiveness of dru report signs of seda anticholinergic sym have a depressed r by scores obtained Social Services will and as needed, to o and provide suppor	des, feeling overwhelmed and go to bed as an escape as life ning. R103 stated her crying oped after starting her ng and monitoring mood se of antidepressants was provided by the facility. IDENT SPECIFIC TARGET TIFIED FOR	F	329			

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		AND HUMAN SERVICES				FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245426	B. WING	à		10/0	06/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY				2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	acceptance toward as needed. Psychia and dementia presiden Encourage residen Encourage residen decision making as verbalization of fee R57's care plan fail behaviors and inter an antipsychotic me On 10/06/16, at 11: care plan and confi specific target beha to the use of the an On 10/06/16, at 3:4 would expect target interventions implet antipsychotic medic A policy for the use was requested, but R57 LACKED COM ASSESSMENT BE HYPNOTIC; ONGO SLEEP FOR EFFE MEDICATION AND NON-PHARMACO BEFORE GIVING H R57's current physi for melatonin 3 mg diagnosis of insom	 bossible. Convey an attitude of resident, listen and reassure atrist consult for depression umed w/o (without) psychosis. t to be involved with facility life. t to continue with daily able to do so. Encourage lings. ed to identify specific target ventions related to the use of edication. 00 a.m., RN-B reviewed R57's rmed R57's care plan lacked aviors and interventions related to the use of edication. 5 p.m., the DON stated she t behaviors to be identified and mented for the use of an cation. of antipsychotic medication not provided. MPREHENSIVE SLEEP FORE STARTING DING MONITORING OF CTIVENESS OF HYPNOTIC THE USE OF LOGICAL INTERVENTIONS HYPNOTIC FOR SLEEP fician orders included an order two hours prior to bedtime for nia, start date 5/5/16. 	F	329			
	R57's current care	plan not dated, included,					

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		AND HUMAN SERVICES			FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245426	B. WING		10/0	06/2016
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
KODA LI	IVING COMMUNITY			255 30TH STREET NW DWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Problem: experience sleep pattern. Apprimedications as orde effectiveness. Moniside effects. Discou caffeine intake. Proto to promote sleep (c clothing, incontinent temperature, ventila disruptions (noise, s light). R57's physician prot through 8/17/16, ide melatonin 3 mg dai On 10/06/16, at 11: a sleep assessment interventions used f melatonin for effect unable to provide a On 10/06/16, at 3:4 monitor sleep habit admission. The DO stated I do not see record for non-phare attempted for sleep hours prior to startint A policy for sleep as not provided. R72 LACKED RES SYMPTOMS TO JU ANTI-ANXIETY ME FOR STARTING AN MEDICATION AND	ces insomnia/change in usual oaches: administer ered. Monitor and record itor and report any adverse urage daytime napping. Limit ovide comfortable environment clean bedding, comfortable bed ace care, comfortable ation). Reduce environmental staff disruptions, intercom, ogress notes dated 5/17/16 entified medications included ily two hours prior to bedtime. 200 a.m., RN-B was asked for nt, non-pharmacological for sleep and monitoring tiveness for sleep. RN-B was iny of this information. 25 p.m., the DON stated we as three to five days after 20 and any documentation in R57's rmacological interventions o or documentation of sleep				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245426	B. WING	ì		10/	06/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	IVING COMMUNITY				2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	ANTIPSYCHOTIC I COMPREHENSIVE JUSTIFICATION FC GDR AT THIS TIME R72's quarterly MD severe cognitive im of depression based behaviors and rece R72's current physi Seroquel (antipsych (increased on 8/9/1 behavioral disturbat (antidepressant) 20 start date of 9/20/16 R72's care plan dat symptoms problem medication related to inappropriate/disrup to cognitive deficit a yelling at other reside wandering, and yell Monitor resident for antipsychotic medic Seroquel as ordere behavior endangers Intervene if necessa environment and ap resident begins to b or disruptive, intervo calm manner. R72's care plan fail- the specific sympto	MEDICATION OR A E PHYSICIANS OR NOT ATTEMPTING A E: PS, dated 8/9/16, indicated R72 apairment, had mild symptoms ed on resident interview, had no eived antipsychotic medication. ician orders included orders for hotic) 25 mg twice daily (6) for dementia with ance and Cymbalta (7) mg once daily for anxiety, 6. ted 5/9/16, included behavioral (7) on antipsychotic (atypical) to has socially ptive behavioral symptoms due as evidenced by resident dents at meal times, ling at staff. Approaches: r side effects related to use of cation. Nursing to administer ed. Assess whether the s the resident and/or others. ary. Maintain a calm pproach to the resident. When become socially inappropriate ene and redirect resident in a	F	329			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245426	B. WING		10/	06/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	information regardin starting Cymbalta a being monitored for clinical rational for r physicians compreh it would be contrain R72's physician pro documented justific Cymbalta medicatio of physician justifica Seroquel medicatio information as to wh reduction for the Se impair the resident's instability by exacer	a.m. RN-B was asked for ng the clinical rationale for nd what mood behaviors are reffectiveness. Also the not attempting a GDR or the nensive justification as to why dicated at this time. Also b gress notes lacked ation for the start of the on and lacked documentation ation for the increase in the n or at a minimum to include hy any attempted dose eroquel would be likely to s function or cause psychiatric bating an underlying medical der. RN-B was unable to	F 329	Ð		
	would expect the ph reason for the use of and for the increase DON stated she wo	6 p.m., the DON stated she hysician to document the of the Cymbalta medication a use of the Seroquel. The buld expect the care plan to be of the Cymbalta and specific ety to be identified.				
F 441 SS=D	physician justification provided.	osychotropic medications and on was requested, but not I CONTROL, PREVENT	F 44 ⁻	1		11/15/16
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission				

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		AND HUMAN SERVICES				FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245426	B. WING	i		10/0	06/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY				255 30TH STREET NW DWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa of disease and infe (a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied t (3) Maintains a rece actions related to in (b) Preventing Spre (1) When the Infect determines that a re- prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is ind professional practic (c) Linens Personnel must hai transport linens so infection.	age 30 ction. I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective and of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted ce. ndle, store, process and as to prevent the spread of	1	441		NATE	DATE
	by: Based on observat review, the facility f recommendations f	NT is not met as evidenced tion, interview and document ailed to follow manufactures for cleaning/sanitizing and ipment to prevent infection for			R61 nebulizer tubing and reservoir replaced. Tubing and reservoir is re weekly. All residents who receive nebulizer treatments have their tubi	placed	

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	IPLE CONSTRUCTION		E SURVEY PLETED	
		IDENTIFICATION NUMBER.	A. BUILDIN	NG	COM	LETED	
		245426	B. WING _			06/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
KODA LI	VING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 441	1 of 2 residents (Rehand hygiene was f of infection during t for 1 of 3 residents catheter use and fa chutes and water s sanitized/cleaned a units (Aspen, Oak, facility this had the residents on these Findings include: R61 LACKED SAN NEBULIZER EQUID During an initial tou 1:37 p.m., on the D machine was obser nightstand. It was c mask and medication was observed to be reservoir. On 10/05/16, at 8:4 nebulizer machine the nightstand. It was mask and medication was observed to be reservoir. At 11:13 a observation, trained entered R61's to act (bronchodilator) sol nebulizer equipmer verified R61's nebu connected to tubing reservoir attached a	 51); failed to ensure proper followed to prevent the spread he provision of perineal-care (R126) reviewed for urinary illed to ensure ice machine pigots were properly nd maintained for 3 of the 4 Dawn) kitchenettes in the potential to affect all 59 wings, staff and visitors. ITIZING/STORAGE OF PMENT: r of the facility on 10/3/16, at awn Unit, R61's nebulizer rved to be located on the onnected to tubing with a on reservoir attached. There e moisture in the medication 7 a.m. and 9:44 a.m., R61's was observed to be located on as connected to tubing with a on reservoir attached. There e moisture in the medication a.m., during medication d medication aide (TMA)-A dminister ipratropium-albuterol ution by nebulization. R61's nt remained the same. TMA-A lizer equipment was g with a mask and medication and there was observed to be dication reservoir. When 	F 44		y and PRN. er nded guidelines of a nebulizer lizers reservoirs for one month, one month, and Audits will be the quality DN or designee. y IDT team. will review for cleaning of ervoirs and tubing control tracking ave continued as foda Living ducation related e/changing of e upon hire, skills fair, and on Infection Control e staff will have 1/10/2016. Audits rmed weekly for month for one ne month. Audits orted to the y the DON or provided to QC Dak, and Dawn 2016. Chutes will Chutes will be ness by b. DON or		

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FC	TED: 11/09/2016 DRM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION) DATE SURVEY COMPLETED
	245426	B. WING	i			10/06/2016
NAME OF PROVIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
KODA LIVING COMMUNITY	,			2255 30TH STREET NW OWATONNA, MN 55060		
PREFIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	E (X5) COMPLETION DATE
R61's medication clean the equipm warm water to rin queried if any oth nebulizer medicat medication pass administered R6 Observation with R69's nebulizer machin the medication reduction reduction reduction reduction not cleaned the estated the facility equipment betweeR61's Resident F indicated R61 had medication administered ipra nebulization 0.5 ft 10/5/16 at 8:00 at documentation o medication was setOn 10/06/16, at 3 (DON) stated show nebulizer equipm water and air dry A facility policy for was requested, b	 A provide the equipment after administration of this a.m. TMA-A stated I usually the this are envioded. A replied she had the environment of the the time revealed equipment was connected to a the and moisture was observed in the environment after use. TMA-A policy was to clean the the time revealed equipment after use. TMA-A policy was to clean the the time revealed to a the administration record, dated from the time revealed for the administration of the signed by TMA-A. B p.m., the director of nursing the would expect staff to clean the the time after use by rinsing in warm the equipment. C PERINEAL CARE WITHOUT NG HANDS AFTER SOILING ND BEFORE APPLYING CREAM 		441			

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		AND HUMAN SERVICES				FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATI	E SURVEY PLETED
		245426	B. WING	i		10/	06/2016
NAME OF	PROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY				2255 30TH STREET NW DWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 33	F 4	441			
	(NA)-E was observe R169's front peri ar cleansed bowel mo R169's roommate of and NA-E with soile curtain for R169's s with soiled gloves of cream, applied the applied a clean inco NA-E then removed washed hands. NA-E failed to remo hands prior to touch On 10/06/16, at 10: (RN)-B stated glove hands washed after On 10/06/16, at 3:3 would expect after removed and hands The facility policy P 10/10, included Ste gloves, 9. b. Wash to back, e. Wash th wiping from the bas extending over the disposable items in Remove gloves and container. Wash an	29 a.m., registered nurse es should be removed and r providing peri cares. 0 p.m., the DON stated she providing peri-care gloves be s washed. erineal Care, dated revised ps in the Procedure: 7. Put on the perineal area, wiping front te rectal area thoroughly, se of the labia towards and buttocks, 11. Discard to designated containers, 12. d discard into designated ad dry your hands thoroughly. JGH SANITIZING ICE D BUILD UP ON ICE					

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		AND HUMAN SERVICES			FORM	: 11/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245426	B. WING		10/(06/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KODA LI	VING COMMUNITY			2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	On 10/03/16, at 5:0 Aspen Unit ice mac substance build up chute and the water (NA)-G was observ the ice machine and chute and water sp build up. Licensed p confirmed the ice m spigot had a white s stated she did not k cleaning of the ice m Observation of kitch Oak unit on 10/3/16 chute to have a larg colored buildup on entire chute. At this be removing ice fro residents in the dim Observation of kitch unit on 10/04/2016, chute to have gray/ buildup on the insid Interview and obser p.m. with the Enviro (ESD) verified the id up present. The ESD department takes c stated the chute is soapy water and is treatment. The ESD to John's appliance vinegar isn't cleanir Interview on 10/6/10 Culinary Services D tried to get the chut has extremely hard	4 p.m., observation of the chine revealed a white on the plastic dispenser ice r spigot. Nursing assistant ed to put ice into a glass from d confirmed at the time the ice igot had a white substance oractical nurse (LPN)-E hachine ice chute and water substance build up. LPN-E anow who was responsible for machine. henette ice machine in the 5, at 4:43 p.m. found the ice ge amount of gray/light brown the inside and around the time observed facility staff to m the chute and serving to the ing room. henette ice machine in dawn 10:31 a.m. found the ice light brown/white colored le and around the chute. rvation on 10/6/16, at 2:03 onmental Services Director ce chutes to have scale build 5D stated the culinary are of the ice machines and wiped down daily with regular cleaned weekly with a vinegar D stated there was a quote out for new fixtures since the	F 441			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	11/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY
		245426	B. WING		10/(06/2016
NAME OF	PROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE		
KODA L	IVING COMMUNITY			255 30TH STREET NW DWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETED	
F 441	appliance. The CSI cleaned daily with v is used weekly. The cleaning schedule t when the chutes ne the staff know to cle stated there had be the quote had been expense and only t Facility provided a c dated 10/6/16, whic had not been previo Facility policy titled, 1/13, identifies the rinse the exterior an Sanitize at the appr and de-lime catch t Facility policy titled, identifies cleaning s tasks listed will be p and cleaning tasks appropriate manne cleaning schedules months. Facility pro	D stated the chutes are being warm soapy water and vinegar e CSD stated there wasn't a to alert the culinary staff of beded to be cleaned but stated ean on Friday's. The CSD een a quote six months ago but in denied at that time due to the he chutes had been replaced. quote from John's Appliance ch identified that the ice chutes ously replaced. , "Cleaning Procedures" dated water/ice dispenser, wash and nd catch tray of the dispenser. ropriate PPM dilution. Clean tray and nozzles as needed. , "Cleaning Schedule" undated, schedules with all cleaning provided in the department completed in a timely and er. Policy identifies completed s are to be kept on file for six poided one form dated 10/4/16 vater and ice machines were	F 441			

Facility ID: 00644

If continuation sheet Page 36 of 36

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	FIPLE CONSTRUCTION NG 02 - KODA LIVING COMMUNITY		TE SURVEY MPLETED
		245426	B. WING		10	/05/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060		
X4) İD REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
< 000	INITIAL COMMEN	ſS	КO	00		
	FIRE SAFETY					
	ALLEGATION OF (DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Divisio survey dated 10/5/2	Survey was conducted by the nent of Public Safety - State on. At the time of this initial 2016, KODA Living Community ubstantial compliance with the articipation in				
	Medicare/Medicaid 483.70(a), Life Safe edition of National	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO: Health Care Fire In	R THE FIRE SAFETY		EPO		
	State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145				

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.

TATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		X3) DATE	0938-039 SURVEY LETED
		245426	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	10/0	5/2016
			22	55 30TH STREET NW WATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or po 3. The name and/or responsible for corr prevent a reoccurr KODA Living Com no basement. The constructed in 201 Type V (111) const	state.mn.us and n@state.mn.us PRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done tiency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. munity is a 1-story building with original building was 3 and was determined to be of truction.	K 000			
K 011 SS=E	fire alarm system of detection in the co- corridors, and all m- monitored for auto- notification. The facility has a co- census of 77 at the The requirement a NOT MET as evide NFPA 101 LIFE SA If the building has nonconforming bu- barrier having at let	y sprinkled. The facility has a with full corridor smoke rridors, spaces open to the esidents sleep rooms that is matic fire department capacity of 79 beds and had a e time of the survey. At 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD a common wall with a ilding, the common wall is a fire east a two hour fire resistance of materials as required for the	K 011			11/15/16

Facility ID: 00644

If continuation sheet Page 2 of 5

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	O LE CONSTRUCTION 02 - KODA LIVING COMMUNITY	(X3) DATE COMF	
		245426	B. WING		10/0	5/2016
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 255 30TH STREET NW DWATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 011	corridors and shall self-closing fire door resistance rating 1 19.1.1.4.1, 19.1.1.4 This STANDARD If the building has nonconforming buil barrier having at le rating constructed addition. Commun corridors and shall self-closing fire door resistance rating 1 19.1.1.4.1, 19.1.1.4 On facility tour betw on 10/5/2016, base revealed that the li home has a fire rational frame.	icating openings occur only in be protected by approved ors with at least 11/2 hour fire 8.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 4.2 is not met as evidenced by: a common wall with a lding, the common wall is a fire ast a two hour fire resistance of materials as required for the icating openings occur only in be protected by approved ors with at least 11/2 hour fire 8.1.1.4.1, 18.1.1.4.2, 18.2.3.2,	K 011	A new rubber gasket has been ord for the fire rated door that is locate link hallway connecting Koda to th Owatonna Hospital. The new rubb gasket will replace the worn/ineffe seal. This update will be complete 11/15/2016.	ed in the e er ctive	
	residents, staff and compartment. This deficient prac Facility Maintenand discovery	tice could anect the safety of an d vistors within the smoke tice was confirmed by the ce Director at the time of AFETY CODE STANDARD	K 018			11/15/16
SS=E	constructed to resi Clearance betwee covering is not exc impediment to the devices that releas pulled are permitte positive latching ha	orridor openings shall be st the passage of smoke. n bottom of door and floor ceeding 1 inch. There is no closing of the doors. Hold open se when the door is pushed or ed. Doors shall be provided with ardware. Dutch doors meeting mitted. Roller latches shall be				

Facility ID: 00644

If continuation sheet Page 3 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/04/2016 FORM APPROVED

CENTER	THE DEPOSITE POINTS PROVIDENTS	& MEDICAID SERVICES			0	CONTRACT NUCLEAR AND	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION 2 - KODA LIVING COMMUNITY	(X3) DATE COMF	SURVEY
		245426	B. WING			10/0	5/2016
	PROVIDER OR SUPPLIER			22	REET ADDRESS, CITY, STATE, ZIP CODE 55 30TH STREET NW WATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 018	prohibited. 18.3.6.3 This STANDARD i Doors protecting c constructed to resis Clearance between covering is not exc impediment to the devices that releas pulled are permitte positive latching ha 18.3.6.3.6 are pern prohibited. 18.3.6.3 On facility tour betw on 10/5/2016, base revealed that room do not fit tight in fra This deficient pract	s not met as evidenced by: orridor openings shall be st the passage of smoke. In bottom of door and floor eeding 1 inch. There is no closing of the doors. Hold open e when the door is pushed or d. Doors shall be provided with irdware. Dutch doors meeting hitted. Roller latches shall be ween 10:00 AM and 02:00 PM ed on observation and interview 521 has a fire rated doors that	ΚO	18	The current door seal for room 52 adjusted to eliminate the gap, bring door into compliance. This was cor on 10/19/2016.	ing the	
K 046 SS=D	Facility Maintenand discovery NFPA 101 LIFE SA Emergency lighting is provided automa 18.2.9.1, 19.2.9.1. This STANDARD Emergency lightin is provided automa 18.2.9.1, 19.2.9.1. On facility tour betw on 10/5/2016, base revealed that the e	tice was confirmed by the ce Director at the time of AFETY CODE STANDARD a of at least 1 1/2 hour duration atically in accordance with 7.9. is not met as evidenced by: g of at least 1 1/2 hour duration atically in accordance with 7.9. ween 10:00 AM and 02:00 PM ed on observation and interview mergency lighting unit for the does not light when tested and		46	The emergency lighting unit in the mechanical room was tested and f need 2 new batteries. Two new ba were replaced and the unit is funct properly. A new process was estat for testing emergency lighting funct Findings will be documented on a and yearly basis. This was completed the statement of	ound to tteries tioning blished tion. monthly	11/15/16

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: L3UF21

Facility ID: 00644

If continuation sheet Page 4 of 5

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION 2 - KODA LIVING COMMUNITY		E SURVEY PLETED
		245426	B. WING	_		10/0	05/2016
	PROVIDER OR SUPPLIER			22	REET ADDRESS, CITY, STATE, ZIP CODE 55 30TH STREET NW WATONNA, MN 55060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 046	Continued From pa have no document testing.	age 4 ation of monthly and annual	K 04	46	10/18/2016		
K 062 SS=C	Facility Maintenand discovery NFPA 101 LIFE SA Automatic sprinkle maintained in relial inspected and teste 4.6.12, NFPA 13, N This STANDARD Automatic sprinkle maintained in relial inspected and teste 4.6.12, NFPA 13, N On facility tour betw on 10/5/2016, base revealed or based	is not met as evidenced by: er systems are continuously ble operating condition and are ed periodically. 18.7.6, 19.7.6,	K 0	62	The ceiling tile in the electrical our Dawn neighborhood was re 10/10/2016.		11/15/16
	the (20) residents This deficient prac	tice could affect the safety of within the smoke compartment. tice was confirmed by the ce Director at the time of					

PRINTED: 11/04/2016



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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Koda Living Community October 24, 2016 Page 2

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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minnesc	ota Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00644	B. WING		10/0	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
KODA LI	VING COMMUNITY		I STREET N NA, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE		(X6) DATE 11/02/16

Electronically Signed

Minneso	ta Department of He	alth				///////////////////////////////////////
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		00644	B. WING		(10/0	C)6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KODA LI	VING COMMUNITY		I STREET N NA, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 11/02/16

Electronically Signed

STATE FORM

If continuation sheet 1 of 31

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00644	B. WING			C 06/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
KODA LI	VING COMMUNITY		TH STREET NV NNA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must them State licensure pro- completion date, th corrected prior to e Minnesota Departm On October 3, 4, 5 Department's staff, the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled " II statute/rule out of co	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				
	and replaces the "T correction order. Th findings which are i after the statement evidence by." Follo	To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED C
		00644	B. WING			06/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
KODA LI	VING COMMUNITY		'H STREET N INA, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
		aint investigation(s) were also ne of the licensing survey."				
		complaint H5426025 was nplaint was not substantiated.				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			11/15/1
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observati review, the facility f identifying and mor residents (R61) rev	ent is not met as evidenced ion, interview and document ailed to follow the care plan for itoring bruises for 1 of 3 iewed for non-pressure related failed to follow the care plan		Corrected		
	for interventions for	Pressure related skin Presidents (R47) reviewed for				
	indicated problem: to Plavix administer	ive care plan dated 12/4/15 Resident bruises easily related red for history of Cerebral ry of bruising. Approaches	ł			

STATEME	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		00644	B. WING			C 06/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		2255 30T	H STREET NV	V		
KUDA L		OWATON	NA, MN 5506	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 565	Continued From pa	ge 3	2 565			
	bruising, notify phys and record descript length and width, co presence/absence signs of healing. Mo complaints of pain: quality, alleviating fa R61 was observed had bruises to the t did not reflect ident bruises. On 10/05/2016, at nurse (LPN)-A verifi to have bruising on hands. LPN-A state bruises and implem swelling, pain and t should monitor for t LPN-A verified the to on the bath sheet of not note the bruises skin inspection she stated R61 bruised documented on any resident on the bath bruises. On 10/05/2016, at nurses (DON) state unexplained bruises and an event was of	b continue to monitor for sician as needed. Measure ion of bruise (location, size, olor, surrounding skin, of pain, presence/absence of ponitor and record any location, duration, quantity, actors, aggravating factors. on 10/4/16, at 9:55 a.m., R61 op of her hands. R61's record ification or monitoring of the 11:58 a.m. licensed practical ied through observation R61 the top of her left and right easily any for any nealing. LPN-A stated staff pruises daily during cares. pruises were not documented ated 10/4/16 and stated did s on R61's hands during the completed on 10/4/16. LPN-A easily and stated she just ything new she sees on the n sheets. LPN-A stated R61 we don't document on all of the 12:52 a.m. the director of ed if there are any new or s staff should notify the nurse greated if there was an . The DON stated staff should				
	monitor skin for cha and during baths ar document any skin bruising. The DON yesterday, she wou	anges during personal cares and stated staff should changes, which included stated if R61 had bath Id have expected the bath ected the bruising to R61's				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.			С
		00644	B. WING			06/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ODA LI	VING COMMUNITY		H STREET NV			
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLE DATE
2 565	Continued From pa	age 4	2 565			
	are to document or nurse is also to cor days and should do found on the bath of expected staff to for identifying and mor Using the Care Pla included: certified r responsible for rep any change in the r plan goals and obje or expected outcom achieved. Other sta resident's condition changes to the Nur Minimum Data Set	n Policy dated August 2006 nursing assistants (CNA's) are orting to the Nurse Supervisor resident's condition and care ectives that have not been met nes that have not been aff noting a change in the n must also report those rse Supervisor and/or the (MDS) Assessment mentation must be consistent				
	problem pressure upressure ulcer on la administer schedul to alleviate pain PF (non-slip pad) in whwool boots to BLE pressure mattress pressure, float hee mat, floor nurses/w to perform wound of healing, signs/symp start date revised 1 integrity: resident is related to incontine and the overall nee of daily living, turn a and PRN, remove lives and the pressure and the pressure and the pressure and the pressure and pre	vised 10/04/16, indicated ulcers: resident has stage three eft heel. Approaches included: ed pain medication as ordered RN (as needed), Dycem neelchair at all times, lamb's (bilateral lower extremities), Ai applied to bed to relieve ls while in bed with heel floater yound NP (nurse practitioner) care as ordered, monitor for otoms of infection. Problem 0/6/16, pressure ulcer skin s at risk for skin breakdown ence, diagnosis of dementia, ed for assistance with activities and reposition every two hours Hoyer sling from under n wheelchair and in bed. Do	r			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:	·····		
		00644	B. WING			C 06/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	VING COMMUNITY	2255 30T	H STREET NV	N		
		OWATON	NA, MN 5506	60		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From pa	age 5	2 565			
	systematic skin ins particular attention Report concerns to Keep clean and dry exposure to moistu after each incontine	ng under resident. Conduct a pection during daily cares. Pay to the bony prominences. nursing for prompt treatment. as possible. Minimize skin ure. Provide incontinence care ent episode and use briefs to hygiene and dignity when				
	be in his room, dre wheelchair with the At 7:55 a.m., R47 r wheelchair with the At 8:41 a.m., R47 r wheelchair in the d underneath him an assisting R47 with was observed to be wheelchair to the a remained undernea assisted R47 imme activity room. At 9:- in his wheelchair w the activity room. At 9:- in his wheelchair w the activity room and V R47 from the activit chapel area for bib not been reposition confirmed R47 had WC-A had assisted the activity room. A (NA)-F stated she for R47 into his wheelchair anot repositioned R47 had completed a.m.	B a.m., R47 was observed to ssed and sitting in his Hoyer sling underneath him. emained seated in his Hoyer sling underneath him. emained seated in his ining room with the Hoyer sling d wellness coach (WC)-A was eating. At 9:00 a.m., WC-A e pushing R47 in his ctivity room, the Hoyer sling ath R47. WC-A stated she had ediately after feeding him to the 46 a.m., R47 remained seated ith the sling underneath him in t 9:53 a.m., R47 was not in the VC-B stated she had assisted ty room immediately to the le study. WC-B stated R47 had hed. At 9:53 a.m., WC-A I not been repositioned when d R47 from the dining room to t 9:55 a.m., nursing assistant had assisted NA-E to transfer chair after NA-E had dressed ares. NA-F confirmed she had 47 since. NA-E confirmed she had astated ad repositioned R47 had been				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00644	B. WING			06/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KODA LI	VING COMMUNITY		H STREET NV NA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	confirmed she had 9:58 a.m., WC-A wa hallway towards his fault they did not re to the wellness activistudy. On 10/5/16, at 12:0 Hoyer sling was und seated in his wheel know we always lea when he is seated i been told different. On 10/06/16, at 10: (RN)-B verified R47 sling was to be rem be off loaded every would expect R47 thours and the Hoye planned.	not repositioned R47 since. At as pushing R47 down the room and stated that was my position R47 as I brought him vity and then he went to bible 4 p.m., NA-E confirmed the derneath R47 while R47 was chair. NA-E stated as far as I ave the sling underneath R47 n his wheelchair, I have not 24 a.m., registered nurse 7's care plan read the Hoyer oved and the resident was to two hours. RN-B stated she o be repositioned every two er sling to be removed as care	2 565			
	stated she would ex and the resident to per the plan of care	g the care plan was				
	SUGGESTED MET The director of nurs review and revise p to ensuring the care resident is followed designee could dev and develop a mon	HOD OF CORRECTION: sing (DON) or designee could olicies and procedures related e plan for each individual . The director of nursing or relop a system to educate staff itoring system to ensure staff as directed by the written plan				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (7	(3) DATE SURVEY COMPLETED C
		00644	B. WING		10/06/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
KODA LI	VING COMMUNITY		H STREET N INA, MN 550		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
2 565	Continued From pa	ge 7	2 565		
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570		11/15/16
	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.				
	by: Based on observati review, the facility fa the use of an indwe	ent is not met as evidenced on, interview and document ailed to revise the care plan for elling Foley catheter for 1 of 3 viewed for urinary catheter		Corrected	
	Findings include:	Findings include:			
	order with the start change catheter mo occluded with 14 Fr (cubic centimeters) system, retention o output every shift. F Administration Reco	onthly and as needed if rench catheter with 10 cc balloon for disorder of urinary f urine and Foley catheter			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00644	B. WING			C 10/06/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
KODA LI	VING COMMUNITY		TH STREET NV NNA, MN 5506				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 570	Continued From pa	age 8	2 570				
		rd day of each month and tures for the catheter output red.					
	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.						
	registered nurse (F indwelling Foley ca	n 10/4/16, at 10:25 a.m., RN)-B stated R126 had an theter and the reason for the der urinary system and urinary					
	included problem: t ability to toilet self-r incontinent of bladd interventions of ass incontinent, inspect after each incontine redness, rash, or b as needed and pro toileting. R126's ca include the use of a	roblem start date 5/27/16, toileting/continence, limited in related to weakness. R126 is der and bowel with sist with incontinence care if t condition of perineal area ent episode, report any roken area, use barrier cream vide extensive assistance for the plan failed to be revised to an indwelling Foley catheter elated to the catheter use.					
	care plan failed to i Foley catheter and catheter use. RN-A	29 a.m., RN-B verified R126's dentify R126 had in indwelling interventions related to the stated R126's indwelling reinserted on 8/3/16.					
	stated she would e to be care planned identified why the c	30 p.m., the director of nursing xpect use of a Foley catheter , which included reasons catheter was in use and ciated with the use of the					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00644	B. WING	B. WING		C 10/06/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
KODA LI	VING COMMUNITY		TH STREET NV NNA, MN 5506				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 570	Continued From pa	age 9	2 570				
	A policy for revision but not provided.	n of care plan was requested,					
	The director of nurs develop and impler related to care plan designee, could pro staff related to the revisions. The qual	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures revisions. The DON or ovide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			11/15/16	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on of preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident n bed.	J t				
	by: Based on observat	ent is not met as evidenced ion, interview and document ailed to identify and monitor		Corrected			

STATE FORM

L3UF11

If continuation sheet 10 of 31

	ta Department of He					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
	00644		B. WING			C 06/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KODA LI	VING COMMUNITY		H STREET NV INA, MN 5506			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 10	2 830			
		esidents (R61, R92 and R129) ressure related skin concerns.				
	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.					
	nurse (LPN)-A verified to have bruising on hands. LPN-A state bruises and implem swelling, pain and h should monitor for h LPN-A verified the h on the bath sheet d not note the bruises skin inspection she stated R61 bruised	11:58 a.m. licensed practical ied through observation R61 the top of her left and right ad she would measure the nent monitoring for any nealing. LPN-A stated staff pruises daily during cares. pruises were not documented ated 10/4/16 and stated did s on R61's hands during the completed on 10/4/16. LPN-A easily and stated she just ything new she sees on the				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
	00644		B. WING			C 06/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
KODA LI	VING COMMUNITY		H STREET NV INA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ao 11	2 830	DEFICIENC	(Y)	
	R61 bruises easily of the bruises. R61's progress not "Resident noted to hands. Bruise to lef measuring 7 cm [cc intact. No swelling. measuring 1.2 cm 2 swelling. Resident of bruising. When ask resident stated "I bu bumped them again resting comfortably accessible. Note le Will continue to mo On 10/06/2016, at (NA)-C stated she I with cares, looking she notified the nur concerns during ca the bath aide docur	10:01 a.m. nursing assistant ooked at resident's skin daily for any changes. NA-C stated se when she found any skin res. NA-C stated on bath days nented any skin concerns on stated the nurse looked over				
	nurses (DON) state unexplained bruise and an event was of unexplained bruise monitor skin for cha and during baths an document any skin bruising. The DON yesterday, she wou sheets to have refle	12:52 a.m. the director of ed if they are any new or s staff should notify the nurse created if there was an . The DON stated staff should anges during personal cares nd stated staff should changes, which included stated if R61 had bath Id have expected the bath ected the bruising to R61's tated the nursing assistants				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			C
	00044		B. WING			06/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
KODA LI	VING COMMUNITY		TH STREET NV NNA, MN 5506			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 12	2 830			
		day. The DON stated staff are plan for identifying and ses.				
	provided by the fac R92 was observed R92 had a bruise k between her middle	ed skin concerns and was not				
	registered nurse (F bruise on located of middle finger and r R92's record lacke the bruise. RN-B st when a skin concer be informed. The n	21 a.m., during observation, RN)-B confirmed R92 had a on her right hand between her ing finger. RN-B confirmed d identification or monitoring of tated the facility system was rn is noticed the nurse was to nurse then would create an iter system to monitor the til resolved.	F			
	problem: at risk for needing assistance incontinence and ir Approaches include inspection during d attention to the bor concerns to nursing Problem: receives for bruising and ble observe for signs o injury/trauma, adm	ted revised 6/6/16, indicated skin breakdown related to with cares, increased ncreased weakness. ed: conduct a systematic skin laily cares. Pay particular ny prominences. Report g for prompt treatment. anticoagulant therapy, at risk eeding. Approaches included of active bleeding, protect from inister medication as ordered, long sleeves if tolerable and				
nasota D	monitor labs and vi R92's progress not					

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:				PLETED
		00644	B. WING			C 06/2016
	PROVIDER OR SUPPLIER					
	-NOVIDEN ON SUFFLIEN		TH STREET NV			
(ODA LI	VING COMMUNITY		NNA, MN 5506			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5) COMPLETI
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE
2 830	Continued From pa	age 13	2 830			
	identification or mo	nitoring of the bruise.				
		3 p.m., the DON stated the				
		the nurse regarding any				
	change with skin of can investigate furt	n a daily basis, so the nurse her				
		and on the resident face sheet				
	dentifies unspecified atrial fibrillation.					
	R129 has physician and Coumadin 2 m	n orders for Aspirin 81 mg daily	/			
		nternal Medicine progress note dated 9/21/16,				
	indicates R129 to have an International					
	Normalized Ratio (INR) level of 1.7 with target					
	NR range of 2 to 3. Coumadin (reduces clotting imme) 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 leve					
		to the facility on 9/15/16. A n was put in place upon				
		ary care plan did not identify				
		uising or bleeding related to				
		medications of Aspirin and				
	Coumadin.	Audit form datad 0/1E/10				
	, o	Audit form dated 9/15/16, nave bruising to the right				
		ist. No measurements				
		included. Weekly body audits form taken from the				
		ing assistant) book dated				
		6 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 no	ow have both a CNA and a				
	-	aff's signature with bruise to				
	left forearm/wrist id	lentified. ?7 a.m. R129 was noted to				
	-	e to the top of the left				
	forearm/wrist area.					
		notes and orders from				

STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	COM	E SURVEY PLETED
	00644		B. WING		C 10/06/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
KODA LI	VING COMMUNITY		TH STREET NINNA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	9/15/16 to 10/6/16. forearm/wrist was r order was present f Admission note doe forearm/wrist area. Interview on 10/5/1 assistant (NA)-D st had been present f she finds a bruise s away and has the r Interview on 10/5/1 practical nurse (LP monitored weekly of LPN-B stated R129 mornings with the l 10/4/16. Weekly bo indicated no bruisin good." LPN-B state bruise. Progress no identifies bruise to 5 cm. LPN-B state bruise. Progress no identifies bruise to 5 cm. LPN-B did no of the bruise until re Interview on 10/6/1 and registered nurs plan did not include stated that they wo and RN-C stated ty risk for bruising the LPN-C and RN-C s weekly and that an body audit sheet. W nurse will fill out an determine how the nurse's order to mo LPN-C and RN-C a assessment should the bruise. Interview on 10/6/1	Bruise to top of left not identified or monitored. No to monitor the bruise. es not indicate bruise to left 6, at 7:47 a.m. with nursing ated the bruise was old and or a while. NA-D stated when she reports to the nurse right nurse come in and look at it. 6, at 8:25 a.m. with licensed N)-B stated bruises are during the weekly shower. D's baths are on Tuesday ast bath taking place on ody audit from 10/4/16 ng and identified, "all looked ad he would measure the ote dated 10/5/16, at 2:43 p.m. left forearm measures 5 cm x ot enter an order for monitoring esolved. 6, at 11:30 a.m. with LPN-C se (RN)-C stated R129's care a being at risk for bruising and uld get it care planned. LPN-C rpically residents who are at ir care plans reflect that. stated bruises are monitored aide and nurse complete the Vhen a bruise is identified the event on the bruise, bruise occurred and put in a onitor daily until it's resolved. also stated the weekly skin d include the measurements of 6, at 3:20 p.m. with RN-C		DEFICIENC	Υ)	
nnesota D	stated R129's bruis	e was from an intravenous d used at the hospital and was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00644	B. WING			C 10/06/2016	
NAME OF I	F PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
KODA LI	VING COMMUNITY		H STREET NW				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 15	2 830				
	documented on the stated that orders t entered for bruises on new bruises tha Requested facility p skin conditions. Po Examination and A indicates, "the purp examine and asses abnormalities in he basis for the care p to assess for the, " sores, redness, ed "all assessment da	a. RN-C stated it was a initial body audit form. RN-C o monitor bruises aren't that are present on admission t occur in the facility. policy related to monitoring of licy titled, "Resident ssessment" dated 02/2014, pose of this procedure is to as the resident for any alth status, which provides a olan" Policy identifies the need presence of bruises, pressure ema, rashes." Policy identifies, ta obtained during the be recorded in the resident's					
	director of nursing develop and impler related to supervisi monitoring/docume skin concerns. The provide training for non-pressure relate monitoring/docume	enting of non-pressure related DON or designee, could all nursing staff related to ed skin concerns enting. The quality assessment nmittee could perform random					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			11/15/1	
	comprehensive res	sores. Based on the ident assessment, the director must coordinate the					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
	VING COMMUNITY		H STREET N			
		OWATON	INA, MN 550	060		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From pa	age 16	2 900			
	development of a r provides that:	nursing care plan which				
	without pressure so pressure sores unle condition demonstre authenticates, that B. a resident w receives necessar	to enters the nursing home cores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observat review, the facility f turning and reposit sling when seated the comprehensive	ent is not met as evidenced ion, interview and document failed to provide every two hour ioning and removal of a Hoyer in a wheelchair as directed by e care plan for 1 of 3 residents risk for pressure ulcers.		Corrected		
	6/14/16, indicated l impairment, require transfers, was at ris	num Data Set (MDS) dated R47 had severe cognitive ed total assistance with sk for pressure ulcers, stage two pressure ulcer and ressure ulcer.				
	problem pressure u pressure ulcer on la administer schedul to alleviate pain PF (non-slip pad) in w	vised 10/04/16, indicated ulcers: resident has stage three eft heel. Approaches included: ed pain medication as ordered RN (as needed), Dycem neelchair at all times, lamb's (bilateral lower extremities),				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			С
		00644	B. WING			06/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
KODA LI	VING COMMUNITY		H STREET NW NA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa		2 900	DEFICIENC	(Y)	
	relieve pressure, flo floater mat, floor nu practitioner) to perfi- monitor for healing, Problem start date ulcer skin integrity: breakdown related dementia, and the o with activities of date every two hours and from under resident bed. Do not leave h	e mattress) applied to bed to bat heels while in bed with heel irrses/wound NP (nurse orm wound care as ordered, signs/symptoms of infection. revised 10/6/16, pressure resident is at risk for skin to incontinence, diagnosis of overall need for assistance ily living, turn and reposition d PRN, remove Hoyer sling t when up in wheelchair and in Hoyer sling under resident. ttic skin inspection during daily				
	cares. Pay particula prominences. Repo prompt treatment. If possible. Minimize Provide incontinence episode and use br hygiene and dignity R47's Wound Sum	ar attention to the bony ort concerns to nursing for Keep clean and dry as skin exposure to moisture. ce care after each incontinent iefs to maintain personal when incontinent. mary Report dated 9/21/16,				
	buttock wound: wou On 10/5/16, at 7:08 be in his room, dres wheelchair with the At 7:55 a.m., R47 ro wheelchair with the At 8:41 a.m., R47 ro wheelchair in the di underneath him and assisting R47 with o was observed to be	a.m., R47 was observed to ssed and sitting in his Hoyer sling underneath him. emained seated in his Hoyer sling underneath him. emained seated in his ning room with the Hoyer sling d wellness coach (WC)-A was eating. At 9:00 a.m., WC-A e pushing R47 in his ctivity room, the Hoyer sling				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00644	B. WING		C 10/06/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
KODA LI	VING COMMUNITY		'H STREET NV INA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	in his wheelchair w	age 18 ith the sling underneath him in t 9:53 a.m., R47 was not in the				
	R47 from the activit chapel area for biblin ot been reposition confirmed R47 had WC-A had assisted the activity room. A (NA)-F stated she find R47 into his wheeld R47 during a.m. can ot repositioned R4 had completed a.m. the last time she had after she had dress confirmed she had 9:58 a.m., WC-A w hallway towards his fault they did not re	VC-B stated she had assisted ty room immediately to the le study. WC-B stated R47 had ned. At 9:53 a.m., WC-A I not been repositioned when d R47 from the dining room to at 9:55 a.m., nursing assistant had assisted NA-E to transfer chair after NA-E had dressed ures. NA-F confirmed she had 47 since. NA-E confirmed she h. cares for R47 and had stated ad repositioned R47 had been sed R47 this morning. NA-E not repositioned R47 since. At ras pushing R47 down the s room and stated that was my eposition R47 as I brought him ivity and then he went to bible	1			
	Hoyer sling was un seated in his wheel know we always lea	04 p.m., NA-E confirmed the iderneath R47 while R47 was lchair. NA-E stated as far as I ave the sling underneath R47 in his wheelchair, I have not y.				
	(RN)-B verified R47 was to be removed loaded every two h expect R47 to be re	24 a.m., registered nurse 7's care plan read the sling and the resident was to be off ours. RN-B stated she would epositioned every two hours removed as care planned.				
pacota D	nurse (LPN)-D stat	i4 a.m., licensed practical ed R47 had prior pressure cks, but the areas healed a				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00644	B. WING			C 06/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KODA LI			H STREET NV NA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 19	2 900			
	couple of weeks ag	0.				
	would expect the sl	2 p.m., the DON stated she ing to be removed and the aded every two hours per the				
		e ulcer skin conditions and lan was requested, but not				
	director of nursing or responsible for givin the care plan exact	HOD OF CORRECTION: The could in-service all staff ng cares/services on following ly as assessed to promote t pressure ulcers from				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary ral	21535			11/15/16
	must be free from u unnecessary drug is A. in excessive therapy; B. for excessiv C. without adec D. in the prese which indicate the o discontinued. In addition to the d	quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in				
	with provisions in th	e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED C
		00644	B. WING			06/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
KODA LI	VING COMMUNITY		TH STREET N NNA, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 20	21535			
	Operations Manual Long-Term Care Fa Department of Hea Health Care Financ This standard is inc available through th	Appendix P of the State , Guidance to Surveyors for acilities, published by the lth and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan the Law Library. It is not change.				
	by: Based on interview facility failed to ider to determine if an a for depression for 1 to identify resident the use of an antips a comprehensive s document physician melatonin (hormon residents (R57) and specific symptoms medication to deter attempt a tapering detailed physician j was contraindicated antipsychotic and a	ent is not met as evidenced and document review the ntify specific mood symptoms antidepressant was affective of 5 residents (R103); failed specific target behaviors for sychotic medication, complete leep assessment and n justification for the use of e) for sleep aide for 1 of 5 d failed to identify resident for use of an anti-anxiety mine if it is affective, also reduction or document a ustification as to why tapering d at this time for the use of an intidepressant medications for 72) reviewed for unnecessary		Corrected		
	SYMPTOMS TO D	SIDENT SPECIFIC MOOD ETERMINE IF T WAS AFFECTIVE:				
		inimum Data Set (MDS), datec R103 was cognitively intact,	ł			

STATE FORM

STATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C	
		00644	B. WING	B. WING		10/06/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
KODA LI	VING COMMUNITY		TH STREET NV NA, MN 5506				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 21	21535				
	interview. R103's care plan d Problem: Resident and anxiety and is Approaches include with resident quarte complete PHQ-9 A status questionnair to assist in monitor provider of significa mood. Staff to ence and concerns. Liste Resident enjoys 1- R103's physician o orders: Zoloft (antio (milligrams) twice a XL (extended relea daily dated 6/30/16	rders included the following depressant) 100 mg a day dated 8/31/16. Wellbutrin ise antidepressant) 300 mg 5.					
	to 10/5/16 with no r On 10/06/2016, at (NA)-A stated resid displayed very little	otes were reviewed from 7/1/16 mood concerns identified. 9:39 a.m. nursing assistant lent was very quiet and emotion. NA-A stated R103 mood or behavioral concerns.					
		2:00 p.m. nursing assistant had not noticed any mood or for R103.					
	(RN)-B stated spec been identified for f for R103. RN-B sta symptoms and doc the progress notes	9:41 a.m. registered nurse cific mood symptoms had not the use of the antidepressants ated staff monitor general mood cument any mood concerns in Irses put events into the					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			-			С	
		00644	B. WING		10/	/06/2016	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
KODA LI	VING COMMUNITY		'H STREET NW INA, MN 5506				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	ige 22	21535				
	medication added of document each shi stated if there were during that time, the practitioner for furth On 10/05/2016, at nurses (DON) state identified and moni antidepressants. Th plan should have ic symptoms for moni reviewing R103's c determine what mo DON stated R103's	record when there is a or changed and the nurses ft for a couple of weeks. RN-B e changes in mood or behavior e nurse notified the nurse her review. 12:43 p.m. the director of ed mood symptoms should be tored for residents on he DON stated R103's care lentified specific mood toring. The DON stated by are plan she was unable to nod concerns R103 had. The s progress notes indicated she herative and orientated per her					
	mood symptoms in having crying episo stated she used to was very overwhelr	3:01 p.m. R103 stated her cluded being tearful and des, feeling overwhelmed and go to bed as an escape as life ning. R103 stated her crying oped after starting her					
	symptoms for the u requested and not						
	was cognitively inta	S, dated 8/4/16, indicated R57 act, had moderate symptoms or on resident interview and had					
	B57's current physi	ician orders included an order					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00014	B. WING			C 10/06/2016	
		00644					
			DDRESS, CITY, S ⁻ T H STREET NV				
KODA LI	VING COMMUNITY		NNA, MN 5506				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 23	21535				
		ipsychotic) 5 mg every sis of dementia with behaviora					
	diagnosis of major administer medicat every shift as order use: at risk for adve receiving antidepre of depression. App effectiveness of dru report signs of seda anticholinergic sym have a depressed of by scores obtained Social Services will and as needed, to and provide suppor resident's mood. Al over situations as p acceptance toward as needed. Psychia and dementia press Encourage residen Encourage residen decision making as verbalization of fee	-					
	behaviors and inter an antipsychotic m						
	care plan and confi specific target beha	:00 a.m., RN-B reviewed R57's irmed R57's care plan lacked aviors and interventions related htipsychotic medication.					
		5 p.m., the DON stated she t behaviors to be identified and	1				

If continuation sheet 24 of 31

	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00644	B. WING			C 06/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
KODA LI			H STREET NV			
			INA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ige 24	21535			
	interventions imple antipsychotic medic	mented for the use of an cation.				
	A policy for the use was requested, but	of antipsychotic medication not provided.				
	ASSESSMENT BE HYPNOTIC; ONGC SLEEP FOR EFFE MEDICATION AND NON-PHARMACO	DING MONITORING OF CTIVENESS OF HYPNOTIC				
	for melatonin 3 mg	ician orders included an order two hours prior to bedtime for nia, start date 5/5/16.				
	Problem: experience sleep pattern. Appr medications as ord effectiveness. Moni side effects. Discou caffeine intake. Pro to promote sleep (c clothing, incontinen temperature, ventila	plan not dated, included, ces insomnia/change in usual oaches: administer ered. Monitor and record itor and report any adverse urage daytime napping. Limit ovide comfortable environment clean bedding, comfortable bed ice care, comfortable ation). Reduce environmental staff disruptions, intercom,				
	through 8/17/16, ide	ogress notes dated 5/17/16 entified medications included ly two hours prior to bedtime.				
	a sleep assessmen interventions used melatonin for effect	00 a.m., RN-B was asked for it, non-pharmacological for sleep and monitoring tiveness for sleep. RN-B was ny of this information.				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00644	B. WING	B. WING		C 06/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
KODA LI	IVING COMMUNITY		TH STREET NV NNA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 25	21535			
	monitor sleep habit admission. The DC stated I do not see record for non-phar attempted for sleep hours prior to starti	45 p.m., the DON stated we ts three to five days after DN reviewed R57's record and any documentation in R57's rmacological interventions o or documentation of sleep ng the melatonin. ssessment was requested, bu	•			
	not provided.	ssessment was requested, bu				
	SYMPTOMS TO JI ANTI-ANXIETY ME FOR STARTING A MEDICATION AND DOSE REDUCTIO ANTIPSYCHOTIC COMPREHENSIVE	OR NOT ATTEMPTING A				
	severe cognitive im of depression base	PS, dated 8/9/16, indicated R72 npairment, had mild symptoms ed on resident interview, had no vived antipsychotic medication.	o			
	Seroquel (antipsycl (increased on 8/9/1 behavioral disturba) mg once daily for anxiety,	r			
	symptoms problem medication related inappropriate/disru	ted 5/9/16, included behaviora : on antipsychotic (atypical) to has socially ptive behavioral symptoms due as evidenced by resident				

Construction C 00644 B. WING C 10/06/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 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) D PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) PREFIX TAG CONTINUE APPROPRIATE DEFICIENCY) (X5) PREFIX TAG CONTINUE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) PREFIX TAG CONTINUE ACTION PREFIX TAG (X5) PREFIX PREFIX TAG (X5) PREFIX PREFIX TAG (X6) PREFIX PREFIX TAG (X6) PREFIX PR		NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
Induction Induction Image: Construction of the second starting Cymbalta medication. STREET ADDRESS, CITY, STATE, ZIP CODE CODA LIVING COMMUNITY 2255 30TH STREET NW OWATONNA, MN 55060 (K4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG IP PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X2) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X2) (X3) 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 and what mood behaviors are					· · · · · · · · · · · · · · · · · · ·		С
CODA 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 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMUNITY 21535 Continued From page 26 21535 (EACH DEFICIENCY 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 in a calm manner. Intervene and redirect resident in a calm manner. F72'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 istarting Cymbalta and what mood behaviors are Interventions related to the use of the Cymbalta and what mood behaviors are			00644	B. WING		10/	06/2016
CODA LIVING COMMUNITY 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X2) COMPLET DATE 21535 Continued From page 26 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 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (X3) COMPLET DEFICIENCY	NAME OF I	PROVIDER OR SUPPLIER					
PHÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRÈCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) complete DATE 21535 Continued From page 26 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. NN-B was asked for information regarding the clinical rationale for starting Cymbalta and what mood behaviors are On 10/6/16 at 11:20 a.m. RN-B was asked for	KODA LI	VING COMMUNITY					
TAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)DATE21535Continued From page 26 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 areImage: CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)DATE							
 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 					CROSS-REFERENCED TO	THE APPROPRIATE	
 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 	21535	Continued From pa	age 26	21535			
		wandering, and yel Monitor resident for antipsychotic media Seroquel as ordered behavior endanger Intervene if necess environment and a resident begins to b or disruptive, interv calm manner. R72's care plan fail the specific sympto and interventions re Cymbalta medication On 10/6/16 at 11:20 information regardi starting Cymbalta a	ling at staff. Approaches: r side effects related to use of cation. Nursing to administer ed. Assess whether the s the resident and/or others. eary. Maintain a calm pproach to the resident. When become socially inappropriate rene and redirect resident in a led to be revised to address oms for diagnosis of anxiety elated to the use of the on. 0 a.m. RN-B was asked for ng the clinical rationale for and what mood behaviors are				
		Seroquel medicatic information as to w reduction for the Se impair the resident instability by exace or psychiatric disor	on or at a minimum to include thy any attempted dose eroquel would be likely to 's function or cause psychiatric rbating an underlying medical der. RN-B was unable to				
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.		would expect the p	36 p.m., the DON stated she hysician to document the of the Cymbalta medication				

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDING.			C
		00644	B. WING))6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KODA LI	VING COMMUNITY		H STREET NV INA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 27	21535			
	DON stated she wo revised for the use symptoms for anxie A policy for use of p physician justification provided.	e use of the Seroquel. The buld expect the care plan to be of the Cymbalta and specific ety to be identified. Desychotropic medications and on was requested, but not				
	director of nursing (develop systems to regimens are thoro unnecessary medic could educate all a unnecessary medic could develop a mo	(DON) or designee could ensure resident medication ughly reviewed for cations. The DON or designee opropriate staff on cations. The DON or designee onitoring system to ensure e and report the findings to the				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			11/15/16
	residents shall, at a are legal rights for stay at the facility o treatment and main that these are desc written statement o responsibilities set case of patients ad as defined in sectio statement shall also person 16 years old	tion about rights. Patients and idmission, be told that there their protection during their r throughout their course of itenance in the community and ribed in an accompanying f the applicable rights and forth in this section. In the mitted to residential programs in 253C.01, the written o describe the right of a d or older to request release as 253B.04, subdivision 2, and				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00644		S (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00644	B. WING			10/06/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KODA LI	VING COMMUNITY		I STREET N NA, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	TION SHOULD BE COMPLET THE APPROPRIATE 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.		21800			
	by: Based on interview facility failed to prov Nursing Facility Adv (SNFABN) upon ter A skilled services for R9 and R24) review beneficiary appeal of Findings include: R12 was discharge 8/12/16, and remain days of Medicare A provide R12 and/or SNFABN/Centers for Services (CMS)-10	ent is not met as evidenced and document review, the vide the required Skilled vanced Beneficiary Notice mination of all Medicare Part or 4 of 4 residents (R12, R2, ved for liability notice and rights. d from Medicare Part A on ned in the facility. R12 used 26 coverage. The facility did not her legal representative with a or Medicare and Medicaid 055 to inform her of potential ered services and of her right		Corrected		

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND I LAN OF CONTLECTION			A. BUILDING:		C	
		00644	B. WING			06/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ODA LI			TH STREET NW			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa	age 29	21800			
	5/23/16, and remai discharged on 5/25 Medicare A coverag R2 and/or her legal SNFABN/Centers f Services (CMS)-10 liability for non-cove to appeal the denia R9 was discharged 5/26/16, and remai days of Medicare A provide R9 and/or I SNFABN/Centers f Services (CMS)-10	I from Medicare Part A on ned in the facility. R9 used 39 coverage. The facility did not her legal representative with a or Medicare and Medicaid 1055 to inform her of potential ered services and of her right				
	8/16/16, and remai days of Medicare A provide R24 and/or SNFABN/Centers f Services (CMS)-10	ed from Medicare Part A on ned in the facility. R24 used 40 coverage. The facility did not r his legal representative with a or Medicare and Medicaid 1055 to inform her of potential ered services and of her right Il to Medicare.				
	registered nurse (F stopped providing t facility as they were RN-A stated it was through the survey were required for re	on 10/06/2016 at 10:33 a.m. RN)-A stated the facility the SNFABN to residents in the told it was no longer required brought to her attention process the SNFABN notices esidents that remained in the d she would re-implement the shy.				
	The facility policy re facility) DETERMIN	elated to SNF (skilled nursing				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00644	B. WING		10/	06/2016
IAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST			
(ODA LI			'H STREET NV INA, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa STAY was requested	-	21800			
	The administrator of review, and/or revise ensure staff are eduliability notices to pro- Medicare services, are communicated The administrator of appropriate staff or The administrator of monitoring systems compliance.	THOD OF CORRECTION: or designee could develop, se policies and procedures to ucated on the appropriate rovide residents at the end of and to ensure resident rights appropriately and acted upon. or designee could educate all of the policies and procedures. or designee could develop at to ensure ongoing R CORRECTION: Twenty-one				
nnesota De ATE FORM	epartment of Health		6899		If continuati	