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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LZCD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00644

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

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **03/01/2016** (L34)

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

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

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : Lisa Carey, HFE NE II 03/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 03/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00450** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245426

March 9, 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 February 19, 2016 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
March 9, 2016

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

RE: Project Number S5426027

Dear Mr. Vandergon:

On January 27, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 14, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 6, 2016 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 January 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 19, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 14, 2016, effective February 19, 2016 and therefore remedies outlined in our letter to you dated January 27, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245426 Y1	A. Building B. Wing Y2	3/1/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0282	Correction	ID Prefix F0314	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(c)	Completed
LSC	02/19/2016	LSC	02/19/2016	LSC	02/19/2016
ID Prefix F0325	Correction	ID Prefix F0329	Correction	ID Prefix F0371	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.35(i)	Completed
LSC	02/19/2016	LSC	02/19/2016	LSC	02/19/2016
ID Prefix F0428	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed
LSC	02/19/2016	LSC	02/19/2016	LSC	02/19/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	3/9/2016	34985	3/1/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/14/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245426 (Y1)	A. Building 02 - KODA LIVING COMMUNITY B. Wing (Y2)	2/6/2016 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 02/06/2016	ID Prefix Reg. # NFPA 101 LSC K0021	Correction Completed 02/06/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	3/9/2016	35482	2/6/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
1/12/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LZCD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00644

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **01/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Justin Main, HFE NE II 02/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/04/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00450** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

January 27, 2016

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

RE: Project Number S5426027

Dear Mr. Vandergon:

On January 14, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by [Compliance Due Date()] the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 14, 2016 (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 July 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment of self administration of medication for 1 of 1 resident (R63) who was observed to self-administer an oral medication. Finding include: R63 was observed on 1/11/16, at 4:26 p.m., when licensed practical nurse (LPN)-A approached R63, who was sitting in the dining room at a table. LPN-A had placed a glass of water, containing Miralax (a laxative) medication, on the table in	F 176	Resident are assessed on admission and periodically if conditions change to allow self-administration if they are able. Residents that are determined that they cannot do self-administration then they are monitored during administration. R 63 was identified as a resident who needed to be monitored, and LPN admitted that she failed to observe resident consume the entire glass of Mira lax. Policy in place for self-administration was provided to surveyors, but following is the policy:	2/19/16

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

Electronically Signed | 02/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 1 front of R63. LPN-A informed R63 she needed to drink the water as there was medication in the water and walked out of the dining room. LPN-A failed to ensure R63 had taken the medication. R63's self administration of medication assessment, dated 2/24/15, indicated staff will administer all medications to R63. During interview on 1/11/16, at 12:30 p.m., LPN-A verified she had placed the glass of water containing Miralax medication on the table in front of R63 and had walked out of the dining room and had not watched R63 take the medication. LPN-A stated R63 was not able to self-administer medications. LPN-A stated she should have watched R63 take the medication. On 1/13/16, at 7:26 a.m., the director of nursing (DON) stated she would expect staff to stay with a resident until the medication was taken, unless the resident was identified to be able to self-administer medication. The DON confirmed R63 was not able to self-administer medications. A policy for self-administration of medication was requested, but not provided.	F 176	Policy statement Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. Policy Interpretation and Implementation 1. As part of their overall evaluation, the staff and practitioner will assess each resident□s mental and physical abilities, to determine whether a resident is capable of self-administering medications 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident□s: a) Ability to read and understand medication labels b) Comprehension of the purpose and proper dosage and administration time for his or her medication c) Ability to remove medication from a container and to ingest and swallow (or otherwise administer) them; and d) Ability to recognize risks and major adverse consequences of his or her medication 3. If the staff determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident□s medication. 4. The staff and practitioner will ask residents who are identified as being able to self-administer medication whether they wish to do so. 5. The staff and practitioner will document their findings and the choices of residents who are potentially capable of self-administering medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 2	F 176	6. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken 7. If the resident is able and willing to take responsibility for documenting their self-administration of medications, the resident is asked to complete a bedside record indicating the administration of the medication (if bedside storage is to be used). 8. Self-administrated medications must be stored in a safe and secure place, which is not accessible by other resident. If safe storage is not possible in the resident□s room, the medication s of residents permitted in self-administer will be stored on a central medication care or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them 9. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not for bedside storage, for return to the family or responsible party upon admit. 10. Facility will reorder medications stored at the bedside in the same manner as other medication 11. The nursing still will rotate bedside stock and will remove expired, discontinued, or recalled medication 12. Nursing staff will review the bedside medication record on each nursing shift, and they will transfer pertinent information to the medication administration record (MAR) kept at the nursing station appropriately noting the doses were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 3	F 176	self-administered 13. The staff and practitioner will periodically (for example, during quarterly MDS reviews) reevaluate a resident□s ability to continue to self-administer medication Nursing Services Policy and Procedure Manual for Long-Term Care Copyright □ 2001 MED_PASS, Inc. (Revised December 2012) Audits will be completed for 4 days a week under the direction of the Unit Managers on different shifts to assure that the nursing staff observe residents that are not doing self-administration consuming all medications as ordered. Audits will be provided to the Director of Clinical Manger as to compliance. Compliance will be achieved by February 19th, 2016.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 1 of 3 residents (R75) reviewed for accidents. Findings include: R75's Resident Admission Record, dated 12/8/15,	F 282	All residents once admitted to the facility as to their physical abilities, and if they require any safety equipment. If they should decline in function throughout their stay, then PT/or OT would again evaluate what the resident would benefit from at in their functional level. Quarterly, residents	2/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4 indicated that the resident had diagnoses of dementia without behavioral disturbance, muscle weakness, weakness and unspecified abnormalities of gait and mobility. R75's Care Plan, dated 12/15/15, stated that the resident was at risk for falls related to a history of falls, dementia, dependence upon staff for assistance with ambulation and transfers. The resident had also been seen attempting to stand up from his wheelchair. Goals identified were that R75 would remain free from injury. Interventions put in place on 12/15/15 to attain this goal were to keep R75's call light within reach, keep his bed in the lowest position with the brakes locked and to provide well maintained footwear; on 12/31/15 interventions were updated to have R75's wheelchair away from his bed when the resident was lying down; on 1/10/16, another invention stated that R75's floor mat was to be placed next to his bed when he was lying down; on 1/11/16, R75's care plan was updated again and stated to have the staff get the resident up earlier in the morning in order to anticipate the need to use the bathroom and get ready for breakfast. R75's Minimum Data Set (MDS), dated 12/21/15, stated that the resident did not have any falls since admission and was dependent of staff for activities of daily living. R75's Interdisciplinary Notes, reviewed from 12/8/15 through 1/14/16, indicated that the resident had fallen on 12/31/15 and 1/10/16. During an observation on 1/13/16 at 7:13 a.m., R75 was currently resting in bed. He was noticed to be edging towards the right side of his bed with both legs out of bed. His legs were moving. There	F 282	again are evaluated by nursing to identify if there are safety needs for the resident, and request evaluation of the appropriate department. Resident - R75 was assessed and identified as a fall risk, so therefore it was determined that floor mats needed to be placed. Care plan was updated to identify that the resident should have pads on the right side, because this was where he attempted to exit the bed. They had misunderstood thinking that he was attempting to get out of his right side, which would be the left side of the bed. After we were alerted to the situation, there are now two mats, one on the left, and one on the right side. Care plan is also updated to have both mats on floor. Audit is being performed 5 times per week on different shifts to assure that the bed is in the lowest position and floor mats are placed on both sides as we do for all residents that are high risk for falling. Audit will initiate and monitored by the Unit Manger and report to the Director of Clinical Manger as to compliance. Compliance will be achieved by February 19th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5	F 282		

was observed to be no floor mat present at the side of the bed. The resident's buttocks and upper body were in bed and his legs were out of bed. The resident was observed to have one gripper sock on his left foot and his right food was bare. At 7:21 a.m., R75 was observed to continue to move his legs while dangling off the right side of the bed. There was no floor mat present on the floor of the right side of the bed.

During an observation on 1/13/16 at 7:26 a.m., there continued to be no fall mat on the right side of the bed. R75's bed was aligned in his room so that the head of the bed was braced against the wall; it was lying so there was space on both sides of his bed. The left side of R75's bed had space between the bed and the window. Upon further inspection, there appeared to be a fall mat on the left side of the bed. At 7:27 a.m., R75 was observed to be moving his legs off the right side of the bed; he was alternating between putting his feet on the floor and gyrating them in the air.

When interviewed on 1/13/16 at 8:36 a.m., Nursing Assistant (NA)-A, stated that R75 was anxious in the morning approximately once a week to the point where the resident appeared to try to get out of bed by himself. NA-A stated that she was not sure why the resident only had one floor mat on the left side of his bed. She stated that it would be a good safety precaution to have a floor mat on either side of his bed. She stated that a lot of other residents who have fall mats would have them on both sides of the bed. NA-A stated that R75 had crawled out of his bed before.

When interviewed on 1/13/16 at 11:45 a.m., Nursing Assistant (NA)-A came up to this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6	F 282		

surveyor and stated that she had spoken to a nurse about there not being a floor mat on both sides of R75 ' s bed. She stated the nurse told her she was not sure why the resident only had one floor mat at his bedside.

When interviewed on 1/13/16 at 11:50 a.m., Registered Nurse (RN)-D stated that R75 had two falls since he was admitted to the facility. She stated that during one fall he did suffer an abrasion to his right knee. She stated that he fell on 1/10/16 and that was the reason that the facility put a floor mat in place. She stated that only one fall mat had been placed at the side of R75's bed. She stated that there was no mention in the interdisciplinary notes which side of the bed R75 had fallen out of; nor did the care plan state which side of the bed to put the floor mat. She stated that now that R75 had been trying to get out of bed they would put a floor mat on either side of his bed.

When interviewed on 1/14/16 at 10:08 a.m., Registered Nurse (RN)-D stated that the nursing assistant had placed the floor mat on the wrong side of R75's bed. She stated that the mat should have been placed on the right side of his bed. She stated that the staff would anticipate R75 getting up earlier.

When interviewed on 1/14/16 at 12:36 p.m., the Director of Nursing (DON) stated that it would have been her expectation that the staff would have followed the care plan. She stated that R75 should have had fall mats on both sides of his bed and that the facility did get fall mats to be placed on both sides of his bed.

Review of the facility policy titled, Care Plans-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 Comprehensive (revised September 2010), stated that the comprehensive care plan was based on a thorough assessment; it was designed to incorporate identified problem areas and risk factors associated with identified problems. It stated that care plan interventions were designed after careful consideration of the relationship between the resident's problem areas and their causes. It stated that assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow physician treatment orders for 2 of 3 residents (R44 & R58) reviewed for pressure ulcers. Findings include: R44's quarterly Minimum Data Set (MDS) dated 12/15/15, identified R44 was at risk for pressure ulcer, had one stage two pressure ulcer, had one	F 314	An Interdisciplinary Team reviews all residents and identify resident that are at high risk for wound development. These residents are reassessed and reviewed during the Interdisciplinary Team Meetings daily as the needs arise. During the meeting the Certified Wound Nurse is updated with changes and assesses what their course of prevention should be so there are no issues with breakdown.	2/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8 unstageable pressure ulcer on heels and had diagnoses of dementia and diabetes. R44's physician orders, dated 1/5/16, identified diagnoses of ulcer left heel and ulcer right heel and directed dressing instructions for wounds left and right heels: 3. wash hands 4. remove old dressing 5. moisten gauze with 0.25 percent acetic acid solution (bactericidal) 6. apply gauze directly to wound base 7. allow gauze to sit for 10-15 minutes 8. remove acetic gauze soak 9. gently cleanse ulcer base with gauze and distilled water 10. moisten acticoat 7 (antimicrobial silver) dressing with distilled water and apply to ulcer base 11. cover with dry gauze and secure with roll gauze. 12. change dressing daily 13. white cotton stockinet to protect skin 14. apply comprilan (100 percent cotton short stretch bandage) compression wrap in spiral fashion from toes to knees 15. tubigrip (tubular bandage) over the top to help with keeping dressing in place. On 1/13/16, at 6:20 a.m., R44 was in bed and licensed practical nurse (LPN)-B was observed to prep R44 for wound dressing change. LPN-B had placed 4 x 4 gauze pads into a cup to soak, which contained acetic acid. LPN-B donned gloves and removed old dressings from both heels, removed gloves, donned clean gloves and then placed the soaked 4 x 4 pads on to R44's heel and held them in place on the heels. LPN-B then laid the pads onto a pad she had placed on R44's bed	F 314	Residents also have skin assessments done on a weekly basis as well as a Braden Score assessment quarterly to assure that they have no increased risk of skin breakdown Resident 44 has a very descript dressing routine ordered. In review with the nurse providing care to the resident she was immediately educated as to the process of applying clean and sterile dressings. She also had changed the sequencing of the wrap. She has completed return demonstration with the nurse educator. We will be continuing to assess dressing changes on all residents with skin integrity, and a weekly basis to assure that treatments are followed according to the wound care recommendation and dressing application policy. Resident 58 skin integrity has been re-assessed. The care plan has been review and updated based on the assessment. Resident is currently going to the wound clinic because this is a chronic wound, and new orders were received as far as treatment. Care plan was update and to the new treatment and continuing monitoring to make sure that his heels are off the bed, and he continues to keep his feet elevated. Monitoring system in place for checking for heel placement while in bed and also to assure that his feet are elevated when up in wheelchair. This monitoring will be done 6 times a week on different shifts. The Unit Manager and DON will be responsible for making sure that all monitoring is done on a on going basis. Audit will initiate and monitored by the Unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 and placed R44's heels on top of the 4 x 4s laid on the pad. R 44 was observed to lift both of his heels off of the soaked acetic acid 4 x 4 pads repeatedly. In addition, after LPN-B had redressed both heel wounds, LPN-B applied the comprilan compression wrap in spiral fashion, then the white stockinet and then the tubigrip to both of R44's right and left lower extremities. LPN-B failed to maintain the 4 x 4 moistened gauze pads soaked with acetic acid solution in place on R44's heels for 10-15 minutes and failed to apply the white cotton stockinet to protect skin, then the comprilan compression wrap in spiral fashion from toes to knees and then the tubigrip over the top to help with keeping dressing in place as per physician orders directed. On 1/13/16, at 7:13 a.m., LPN-B verified the soaked acetic acid 4 x 4 pads had not been in place on R44's heels constantly for 10-15 minutes and R44 had been lifting his heels off of the pads. LPN-B stated R44 usually relaxes enough, but R44 was unpredictable at times and at times R44's heels do stay on the pads for 15 minutes. LPN-B stated she does not use a wrap to hold the acetic soaked 4 x 4's in place for 10-15 minutes. In addition LPN-B verified she had applied the comprilan compression wrap in spiral fashion, then the white stockinet and then the tubigrip to both of R44's right and left lower extremities. On 1/13/16, at 7:22 a.m., the director of nursing (DON) stated she would expect staff to place a wrap over the acetic acid soaked 4 x 4 pads to hold them in place for the 10-15 minutes as per	F 314	Manger and report to the Director of Clinical Manger as to compliance. Compliance will be achieved by February 19th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10	F 314		

treatment orders. The DON stated she would expect staff to follow the wound treatment orders.

A policy for following physician treatment orders was requested, but not provided.
R58's Resident Admission Record, dated 8/15/12, indicated that the resident had diagnoses of: diabetes without complications; pressure ulcer of right heel, unstageable; diabetic foot ulcer, left foot; acquired absence of toe, right side amputation.

R58's interdisciplinary notes, dated 12/30/15, at 6:55 p.m. stated, "Received fax back from [Doctor (Dr)-A] office with Rochester Vascular Center stating Diagnosis for Right heel wound. Per NP [nurse practitioner] on behalf of [Dr-B]. Diagnosis is Pressure Ulcer, right heel."

R58's Physician Order Report, dated 12/4/15, advised the nursing staff to keep pressure off R58's heels at all times. This order was capitalized and had multiple exclamation points included in the order.

R58's Care Plan, dated 6/10/13 (edited on 11/18/15) identified that the resident had impaired skin integrity related to a history of diabetic foot ulcers and a recent right foot 5th toe amputation. There is no intervention to keep the pressure off heels as ordered by the doctor ordered on 12/4/15.
R58's Treatment Administration History (TAH), dated 12/4/15, stated to keep pressure off of R58's heels at all times.

During an observation on 1/13/16 at 9:07 a.m., Licensed Practical Nurse (LPN)-C knocked on R58's door and asked if she could come in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11	F 314		

room. She explained that she was going to do his dressing change and the resident agreed to let this surveyor be present. R58 was lying in bed. He had a blanket covering his legs. The blanket at his feet was elevated due to a foot cradle (used to elevate a blanket to keep off of the toes) in place. After LPN-C had washed her hands, gathered her materials prepared everything to do the dressing change she put on a pair of latex gloves and uncovered the blanket at the legs. R58 had Prevalon boots (used to help minimize pressure on the heels) on both feet. His feet were both resting flat on the mattress at this time. LPN-C put a rolled up pillow under each calf to elevate the heels and have them floating (no pressure to heels). LPN-C then did proceed to perform the ordered dressing changes. At the end of the procedure, LPN-C then applied a clean pair of cotton socks to each leg; on top of that LPN-C applied a compression wrap to each leg without covering the heel. After this was applied, LPN-C then put the Prevalon boots back on and then left each leg elevated by putting a pillow under each calf. LPN-C then did reapply the foot cradle and reapply the blanket to its original position.

When interviewed on 1/13/16 at 9:56 a.m., Licensed Practical Nurse (LPN)-C stated that in her opinion she would want R58's heels elevated by having pillows underneath his calves.

During an observation on 1/14/16 at 9:14 a.m., R58 was in his room watching television. He was sitting in his wheelchair with his feet dangling in a dependent position not touching the floor. The foot pedals were attached to his chair but they were pulled to the side not being utilized.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 When interviewed on 1/14/16 at 9:18 a.m., Licensed Practical Nurse (LPN)-D stated that she was not too familiar with R58. She then did raise the residents legs by placing them in the foot pedals in his wheelchair. She stated that the repercussions of not elevating the heels when pressure ulcers were present were that they could get worse. She stated that she would educate the nursing assistants' that R58's heels would need to be elevated. When interviewed on 1/14/16 at 12:39 p.m. the Director of nursing stated that the physicians order to have R58's heels elevated at all times should have been documented in the electronic care plan. She explained when an order comes through from the physician or the care plan was updated then that information would transfer over to the nursing assistant staff and all nursing assistants would then have access to what cares each resident would have. The facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol (Revised March 2014), it stated that the physician would authorize pertinent orders related to wound treatments.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		2/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to address a severe weight loss for 1 of 3 residents (R40) reviewed for nutrition. Findings include: R40's annual Minimum Data Set (MDS) dated 8/6/15, identified a weight of 127 pounds. R40's quarterly MDS dated 11/3/15, identified a weight of 114 pounds, weight loss of five percent or more in the last month or loss of 10 percent or more in the last six months, mechanical altered diet and R40 required staff assist to eat. R40 experienced a thirteen pound weight loss in three months (severe or greater than 7.5 percent). On 1/13/16, at 8:19 a.m., observation revealed R40 had eaten 100 percent of the breakfast meal. R40's care plan edited date 3/5/15, identified requires assistance with eating and drinking due to cognitive deficit with interventions of pureed diet, nectar thick liquids, monitor/record weight per physician orders and resident will be assisted with feeding at meals by one staff. Care plan problem edited date 11/9/15, at risk for inadequate intake related to dementia, will maintain weight between 120-130 pounds with interventions of provide diet as ordered, encourage to make choices from select menus,	F 325	All residents are weighed upon admission, and the RD reviews their weight and makes recommendations as to what the resident is in need of. Then quarterly the CDM reviews the residents intake, their weight and recommendations are sent forward to the IDT if there are needing any changes. During the care conferences the CDM does talk with the resident and family as to what if any recommendations they would have that the resident would like to assist in their dietary needs. Resident 40 weight has fluctuated the last few months. In review the dietary recommendations with a weight of 114 on 11/3/15 was to provide thickened liquid and needing 1306 calories per day which included 58 grams of protein and 1300 ml of fluid. On 1/13/16 RD review her recorded intake and according to her discussion with the family in November they stated that they would prefer she would stay in the range of 115. RD recommended that she should be between 110-120 and her intake is adequate. On 1/26/16 the assessment again was made with the resident at 113 pounds which is a one pound weight loss from last quarter. Again the RD recommended that with this weight the diet is to continue with the 1306 calories daily which includes 58 grams of protein	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 14 monitor weight and intake routinely. R40's facility nutrition assessment, dated 8/4/15, identified a weight of 127 pounds and dated 11/3/15, identified current diet order pureed and nectar thick liquids. Nourishment/supplement orders, none. Weight 114 pounds on 11/1/15, five percent weight change in 30 days and 7.5 percent weight change in 90 days. Requires assistance with eating and current intake good (equal to or greater than 75 percent). Evaluation of will continue to monitor intakes and weight. Referral to dietician due to a 10 pound weight loss in one month. However, the dietician had not seen R40 to complete a nutritional assessment. R40's resident progress notes dated 11/11/15, identified R40's weight has been stable. Weight 8/13/15 of 117 pounds, 9/13 of 117 pounds, 10/13 of 124 pounds and 11/10 of 124 pounds. Family member (FM-A) is ok with current weight gain as this is around the resident's normal weight. R40 was eating 83 percent of meals and no culinary concerns at this time. R40's vitals report identified the following weights: 6/15/15 -123 pounds 8/4/15 - 127 pounds 9/13/15 - 117 pounds 10/13/15 -124 pounds 11/10/15 - 124 pounds 12/8/15 - 115 pounds (a severe weight loss of greater than five percent in one month). 1/12/16 - 114 pounds. R40's record failed to include documentation of a review by the facility registered dietician regarding the weight loss and notification of R40's primary physician and family regarding the weight loss. In addition, the record lacked documentation of interventions implemented related to the weight	F 325	and 1300 ml of fluid. Currently she is on a weekly weight, and if there is a decline within the 5% weight lost the IDT be notified for further recommendation. We will continue to monitor her weight on weekly basis. Weekly audit will initiate and monitored by the Unit Manger and report to the Director of Clinical Manger as to compliance. Compliance will be achieved by February 19th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 15	F 325		

loss, if there was a discrepancy in weights for R40 and explanation of the discrepancies or documentation indicating the resident could not attain or maintain acceptable parameters of nutritional status.
On 1/13/16, at 12:08 p.m., culinary service director (CSD)-D verified R40's weights. CSD-D verified R40's MDS dated 11/3/15, and R40's nutrition assessment, dated 11/3/15. CSD-D verified there was no documentation in R40's record the registered dietician (RD)-B had reviewed R40 for a weight loss. CSD-D stated normally she discusses weight loss with RD-B and the unit coordinator and a supplement would be put in place. CSD-D reviewed R40's record and confirmed no supplement or intervention had been implemented for weight loss.
On 1/14/16, at 11:53 a.m., CSD-D stated RD-B was at the facility weekly on Tuesdays and Fridays. CSD-D stated she had made a referral for RD-B to review R40 in the facility computer system on 11/3/15, from the nutritional assessment dated 11/3/15 due to 10 pound weight loss in one month, but she had figured out the computer system was not triggering to notify RD-B. CSD-D stated she would not put an intervention in place for weight loss without RD-B's approval.
On 1/14/16, at 12:15 p.m., registered nurse (RN)-A verified R40's progress note 11/11/15, identified R40's weight was 124 pounds and R40's current weight on 1/12/16 was 114 pounds. RN-A stated she was not aware R40 had a 10 pound weight loss. RN-A stated the nursing assistant would weigh the resident and the floor nurse inputs the weight into the computer and would let me know if there was a weight loss or weight increase. RN-A verified the physician and family was not aware of the weight loss, R40 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 16	F 325		

not currently receiving a supplement and stated R40's weight decrease was missed somehow. On 1/14/16, at 1:53 p.m., the director of nursing (DON) stated R40's weight loss is a definite change and she would expect a supplement to be provided. The DON stated she would expect the physician or nurse practitioner, registered dietician and family to be informed of the weight loss. The DON stated she would expect the nursing assistant to communicate the weight of the resident to the nurse on the floor and the nurse to inform the unit charge nurse if there is a change in weight. The unit charge nurse should then notify the physician and family of the weight change. The DON stated the facility should not rely on the computer system to identify a weight loss.

On 1/14/16, at 3:50 p.m., registered dietician (RD)-B stated she is at the facility a total of 12 hours every week. RD-B verified she had not reviewed R40 for a weight loss as she was not informed R40 had a weight loss. RD-B stated the CSD-D informed me she had flagged in the facility computer system a referral to notify me back in 11/15, regarding a weight loss, but there is a problem with the computer system and I never received the notification.

The facility Weighing and Measuring the Resident, dated 3/11, indicated reporting 1. Report significant weight loss/gain to the nurse supervisor.

The facility policy Nutritional Assessment and Nutritional Risk Assessment, undated, indicated a dietician will review all nutritional assessments, summaries and care plan and document the review in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to attempt a taper or document a justification as to why the taper was contraindicated at this time for an antidepressant medication for 1 of 5 residents (R40) reviewed for unnecessary medications. Findings include:	F 329	Each resident□s medication regime is reviewed upon admission and monthly thereafter by the admitting physician and consultant pharmacist. The consultant pharmacist reviews the medications, and also identifies if there are excessive dosing, inappropriate dosing, medication not appropriate for the elderly, and any food and drug interactions. The	2/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 18 R40's quarterly MDS dated 11/3/15, identified diagnoses of dementia, psychotic disorder and depression, had received an antidepressant medication and had no mood or behaviors. R40's care plan problem start date 9/7/14, psychotropic drug use, receives an antidepressant medication related to depressed mood. Resident will appear calm and content, will accept assist from care givers, will smile daily and not exhibit adverse body language. Interventions included provide cares as anticipated, visit with resident, listen if/when she is visiting, encourage verbal interaction as able, social service to follow mood, alert registered nurse coordinator to significant changes in mood, monitor for changes in functional status as needed, monitor residents mood and response to medication, administer med as ordered, pharmacy consultant review per facility policy, assess/record effectiveness of drug treatment, monitor and report signs of sedation, hypotension, or anticholinergic symptoms. R40's physician orders, dated 11/20/15, included an order for Zoloft (an antidepressant) 100 mg (milligrams) once a morning for adjustment disorder with depressed mood. R40's medication administration record dated 1/16, revealed R40 was receiving the Zoloft daily as ordered. R40's physician progress note dated 9/22/15, indicated remains on Zoloft 100 mg daily at the insistence of family, who feels that R40 has had long term issues with depression and the benefit exceeds the risk which they are aware of and continue to decline any dose reduction and dated 11/20/15, indicated on Zoloft for depression and episodes of just weeping that she had previously experienced and those have resolved. Seems to	F 329	recommendations then are forwarded to the physician for them to address. If the physician agrees with the recommendation, then the order is placed. If the physician does not agree, then the reasons are documented on the request form by the pharmacy, and placed in the resident□s chart. Resident 40 has quite an extensive mental health background which consists of diagnosis of dementia, psychotic disorder and depression. During her stay here she has exhibited crying and screaming episodes, and with the adjustment of the medication Zoloft she has now not had those same explosive behaviors. When approaching the family and physician about the GDR, they stated they did not want to change anything because of being less aggressive and no apparent hallucinations and resident is more participative in activities as well as Rehab Nursing. Following is a documentation in the chart from the Unit Manager as to why the GDR was not done: Note Discipline: Nursing Progress Note: Pharmacy recommends GDR for Antidepressants q 21 months. GDR will not be done at this time d/t previous reduction unsuccessful and family requesting that no GDR be done at this time. Date/Time: 09/22/2015 12:32 PM We will continue to review medication records so residents are not subject to excessive or unnecessary medication. Physician will be advised to discuss with the resident, family and consultant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 19 be generally happy although has severe dementia and really is unable to give a history. Has not been noted to be weeping or crying and will often smile and raise arms to give a hug. This was discussed with daughter at quarterly care conference on 11/11 and a gradual dose reduction was declined by daughter into the future. However, the physician progress notes lacked documentation of physician justification at a minimum to include information as to why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. R40's resident progress notes identified the following: On 8/12/15, annual care conference documented by nursing, back in 9/14 resident's daughter had requested R40 get an increase in the Zoloft from 50 mg to 100 mg. No issues have been noted since and resident's daughters are pleased with the current dose. On 11/3/15, quarterly care conference documented by nursing, continues on Zoloft 100 mg daily which has been effective, resident has not presented with any crying or weeping since Zoloft was initiated, family declines any past or future lowering of the medication dose. On 11/11/15, documented by social services, received Zoloft medication for diagnosis of depression and this appears to be working effectively. R40's mood appears stable and R40 has not exhibited any indicators of depressed mood. On 1/14/16, at 12:15 p.m., registered nurse	F 329	pharmacists the risk and benefits of titration of medication, along with respecting the right of the resident and family in the final decision. We will continue to monitor residents that are on psychotropic medications and request GDR. Use of psychotropic medications will be initiate and monitored by the Unit Manger and report to the Director of Clinical Manger as to compliance. Compliance will be achieved by February 19th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 20	F 329		

(RN)-A verified R40's physician progress note 11/11/15. RN-A confirmed R40 had been receiving Zoloft 100 mg since 9/11/14, and no gradual dose reduction had been attempted since 9/14/14. RN-A stated on 9/14/14 the Zoloft was increased from 50 mg to 100 mg and R40's record had no documentation for behaviors indicating why the dose was increased at the time, other than family requested and R40 has had no mood or behaviors documented since the increase. RN-A stated the mood and behaviors are documented in the nurse's notes only when a resident is noted to have any. Monitoring of mood and behaviors is done every shift for a time period only when a dose change occurs. The IDT (interdisciplinary team) reviews the nurse's notes and report sheets quarterly for any documentation of mood and behaviors. RN-A stated she has never observed R40 to have any behaviors. RN-A confirmed the physician response, in regards to the pharmacy recommendation to attempt a titration for the Zoloft dated 9/21/15, was based on family declines. RN-A stated we review R40's Zoloft medication at care conferences and every time we review, R40's mood is stable and the family wants the medication to remain at the same dose.

On 1/14/16, at 1:53 p.m., the director of nursing (DON) stated she would expect the physician to be involved if no behaviors were noted for R40 to review if the medication was appropriate or would we be able to reduce the medication. If a family is declining a reduction, ask the family why they do not want a reduction, educate the family as to why a reduction is recommended and have the physician involved. The DON stated she would expect a risk and benefits to be done with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 21 family as part of the education process. A policy was requested for antidepressant medication and/or physician justification, but was not provided.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishwasher temperature of 180 degrees during the rinse cycle and/or failed to ensure 50 ppm Hypochlorite to minimize the potential for foodborne illness. This had the potential to effect all 67 residents residing in the facility, staff and visitors who utilized dishware. Findings include: On 1/11/16 at 6:06 p.m. during kitchen observation which included the monitoring of the dishwasher to determine if it is functioning correctly to sanitize the dishes. It was learned at this time there dishwashers sanitized using both hot water (rinse temperature at 180 degrees	F 371	Dishwashers are monitored at each meal to assure that all temperatures were within recommended guidelines. A heat strip called Temp Right Dishwasher Temperature Label was used once a shift in all dishwashers. Identified during survey was that there was a lack of documentation of temperature, which has now been initiated since 1/16/16 and evaluated by the CDM. Also Hobart Services, ITW Food Equipment Group LLC was notified and came to evaluate the dishwashers heaters as well as checking the tubing for the cleaning chemicals. Temperature sheets will be initiate and monitored by the CDM for compliance on a daily basis.	2/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 22 Fahrenheit) and chemical sanitation (having chlorine at 50 parts per milliliters). However, when the temperature of the hot water sanitation did not reach 180 degrees Fahrenheit the back-up chemical sanitation was not checked to see if it was at a minimum of 50 ppm. This practice had a high potential that the dishes were not being fully sanitized for resident use. On 1/11/16, at 6:06 p.m., observation of dishwasher temperatures with dietary aide (DA)-A placed a rack level of dishes into the dishwasher and the wash temperature was 138 degrees and the rinse temperature was 171 degrees. DA-A stated the temperature had to be above 150 degrees for the dishwasher. DA-A stated she had tested the dishwasher today and showed surveyor a "Culinary Center Report Sheet", dated 1/11/16, had documented "Dish Machine Temperature" was 164 degrees. The report sheet failed to include recording of a chlorine test paper strip to ensure the chlorine reached 50 parts per million (ppm) and failed to indicate if the temperature of the dishwasher was the wash cycle or rinse cycle. DA-A stated the temperature she was recording for the dishwasher was the wash temperature, not the rinse temperature. DA-A stated she was not aware the temperature had to reach a certain temperature for the rinse cycle. DA-A stated she does not test the dishwasher using a chlorine test paper strip to ensure the chlorine reached 50 parts per million (ppm). The dishwasher machine had a factory label which indicated hot water sanitizing, wash 150 degrees, rinse 180 degrees and chemical	F 371	Compliance will be achieved by February 19th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23 sanitizing wash 120 degrees and rinse 120 degrees. Surveyor intervened and requested to rewash the rack of dishes. DA-A rewashed the rack of dishes and the wash temperature reached 152 degrees and rinse temperature of 178 degrees and for a third time the wash temperature reached 157 degrees and rinse temperature of 178 degrees. DA-A verified the temperature at the time. On 1/11/16, at 6:18 p.m., culinary service director (CSD)-D stated the dishwasher was a combined hot water and chemical dishwasher. CSD-D ran the dishwasher and the wash temperature reached 155 degrees and the rinse temperature reached 186 degrees. CSD-D per request of the surveyor, tested the dishwasher using a chlorine test strip and the strip tested at 50 ppm. CSD-D stated the water is draining out of the machine and that was the reason the temperature was not reaching the appropriate temperature for rinse of 180 degrees. The machine needs to be leveled again. CSD-D stated the strip the staff use to test the temperature of the dishwasher was a test strip that turns orange to indicate the temperature of the water reached 160 degrees. CSD-D verified the staff were not using a chlorine test paper strip to ensure the chlorine reached 50 ppm for the dishwasher. CSD-D stated there was not an area on the report sheet for the staff which indicated to record chlorine test trip results and she would have to fix that. Aspen kitchen dishwasher temperature logs were reviewed from 12/13/15 to 1/12/16. The final rinse temperature did not reach 180 degrees or above 38 out of 41 times the temperature was taken. Of these 38 opportunities there was no	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 24	F 371		

documentation the chemical sanitation of the dishwasher was tested using a chlorine test paper strip to ensure the chlorine reached 50 parts per million (ppm). The logs the facility used to record dish machine temperature lacked a designated area to record the chemical sanitizing results from the dishwasher.
Review of the dishwasher temperatures logs revealed the following:

Main kitchen dishwasher temperature logs were reviewed from 12/28/15 to 1/12/16. The final rinse temperature did not reach 180 degrees or above 23 out of 39 times the temperature was taken. Of these 39 opportunities there was no documentation the chemical sanitation of the dishwasher was tested using a chlorine test paper strip to ensure the chlorine reached 50 parts per million (ppm). The logs the facility used to record dish machine temperature lacked a designated area to record the chemical sanitizing results from the dishwasher.

The Dawn unit dishwasher temperature logs were reviewed from 12/14/15 to 1/14/16. The final rinse temperature did not reach 180 degrees or above 22 out of 22 times the temperature was taken. Of these 22 opportunities there was no documentation the chemical sanitation of the dishwasher was tested using a chlorine test paper strip to ensure the chlorine reached 50 ppm. The logs the facility used to record dish machine temperature lacked a designated area to record the chemical sanitizing results from the dishwasher.

The Kindle/Oak dishwasher temperature logs were reviewed from 12/13/15 to 1/14/16. The final rinse temperature did not reach 180 degrees or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 25	F 371		

above 27 out of 29 times the temperature was taken. Of these 27 opportunities there was no documentation the chemical sanitation of the dishwasher was tested using a chlorine test paper strip to ensure the chlorine reached 50 PPM. The logs the facility used to record dish machine temperature lacked a designated area to record the chemical sanitizing results from the dishwasher.

Review of manufacturer's instructions for the dishwasher in the main kitchen provided by facility, revealed the following directions: operating temperatures-wash (minimum) 160 degrees Fahrenheit and; sanitizing rinse (minimum) 180 degrees Fahrenheit.

On 1/14/16 at 12:11 p.m. the certified dietary manager (CDM) verified by review of the logs the final rinse temperature of the dishwashers was not reaching 180 degrees in the Dawn, Oak and Kindle units and in the main kitchen. The CDM stated the facility did not test for chemical sanitization of these dishwashers and verified the logs did not have a designated spot to record the chemical sanitation. The CDM verified when the final rinse temperatures were lower than 180 degrees, nothing was done by the facility to address the low temperatures. The CDM stated, "As I understood it, I was not concerned the temperatures did not reach 180 degrees for the final rinse as the dishwashing machines had a chemical back-up." The CDM stated the facility was not testing chemical sanitation of the dishwashers when the final rinse temperature was lower than 180 degrees to ensure proper sanitation had been achieved. The CDM verified the facility was not following their policy and procedure or the manufacturer's instructions to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 26 ensure proper sanitation of items washed in the facility dishwashers. The Dishwashing Temperature Monitoring Logs Reviewed/Revised 1/9/15 policy specified, "To ensure that the wash and rinse temperatures and sanitizing chemical if used, are properly monitored and controlled a log must be completed by those who are directly involved in the dishwashing process. Entries must be made daily according to health department regulations and quality assurance standards. Procedure: I. The appropriate dishwashing temperature log is posted in the immediate vicinity of the dishwashing area. II. Wash and rinse temperatures or PPM, are observed and logged by the operator during the dishwashing. III. Temperature and/or PPM that are below required levels are reported to the culinary director immediately for correction of problem before continuing procedure and documented. IV. It is the responsibility of the Culinary Director to monitor daily completion of the dishwashing temperature logs. V. Logs are kept on file for 6 months."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		2/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified lack of documentation of physician justification for the continued need of an antidepressant medication for 1 of 5 residents (R40) reviewed for unnecessary medications. Findings include: R40's quarterly MDS dated 11/3/15, identified diagnoses of dementia, psychotic disorder and depression, had received an antidepressant medication and had no mood or behaviors. R40's physician orders, dated 11/20/15, included an order for Zoloft (an antidepressant) 100 mg (milligrams) once a morning for adjustment disorder with depressed mood. R40's medication administration record dated 1/16, revealed R40 was receiving the Zoloft daily as ordered. R40's physician progress note dated 9/22/15, indicated remains on Zoloft 100 mg daily at the insistence of family, who feels that R40 has had long term issues with depression and the benefit exceeds the risk which they are aware of and continue to decline any dose reduction and dated 11/20/15, indicated on Zoloft for depression and episodes of just weeping that she had previously experienced and those have resolved. Seems to be generally happy although has severe dementia and really is unable to give a history. Has not been noted to be weeping or crying and will often	F 428	Each resident□s medication regime is reviewed upon admission and monthly thereafter by the admitting physician and consultant pharmacist. The consultant pharmacist reviews the medications, and also identifies if there are excessive dosing, inappropriate dosing, medication not appropriate for the elderly, and any food and drug interactions. The recommendations then are forwarded to the physician for them to address. If the physician agrees with the recommendation, then the order is placed. If the physician does not agree, then the reasons are documented on the request form by the pharmacy, and placed in the resident□s chart. Note Discipline: Nursing Progress Note: Pharmacy recommends GDR for Antidepressants q 21 months. GDR will not be done at this time d/t previous reduction unsuccessful and family requesting that no GDR be done at this time. Date/Time: 09/22/2015 12:32 PM We will continue to review medication records so residents are not subject to excessive or unnecessary medication. Physician will be advised to discuss with the resident, family and consultant pharmacists the risk and benefits of titration of medication, along with respecting the right of the resident and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 28 smile and raise arms to give a hug. This was discussed with daughter at quarterly care conference on 11/11 and a gradual dose reduction was declined by daughter into the future. However, the physician progress notes lacked documentation of physician justification at a minimum to include information as to why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. R40's consultant pharmacist recommendation dated 9/21/15, identified consider a gradual dose reduction (GDR) attempt for Zoloft. Last dose adjustment was 9/14. The physician response was family declines GDR, dated 9/22/15. R40's progress notes indicated for the consultant pharmacist reviews on 10/25/15, 11/18/15 and 12/28/15, medication regime reviewed, no recommendations at this time. R40's record lacked documentation of recommendation for physician justification by the consultant pharmacist for the decline of a GDR for the Zoloft. On 1/14/16, at 12:15 p.m., registered nurse (RN)-A verified R40's physician progress note 11/11/15. RN-A confirmed R40 had been receiving Zoloft 100 mg since 9/11/14, and no gradual dose reduction had been attempted since 9/14/14. RN-A stated on 9/14/14 the Zoloft was increased from 50 mg to 100 mg and R40's record had no documentation for behaviors indicating why the dose was increased at the	F 428	family in the final decision. We will continue to monitor residents that are on psychotropic medications and request GDR. Use of psychotropic medications will be initiate and monitored by the Unit Manger and report to the Director of Clinical Manger as to compliance. Compliance will be achieved by February 19th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 29	F 428		

time, other than family requested and R40 has had no mood or behaviors documented since the increase. RN-A stated she has never observed R40 to have any behaviors. RN-A confirmed the physician response, in regards to the pharmacy recommendation to attempt a GDR for the Zoloft dated 9/21/15, was family declines GDR. RN-A stated we review R40's Zoloft medication at care conferences and every time we review, R40's mood is stable and the family wants the medication to remain at the same dose.

On 1/14/16, at 1:53 p.m., the director of nursing (DON) stated she would expect the physician to be involved if no behaviors were noted for R40 to review if the medication was appropriate or would we be able to reduce the medication. If a family is declining a reduction, ask the family why they do not want a reduction, educate the family as to why a reduction is recommended and have the physician involved. The DON stated she would expect a consultant pharmacist recommendation of physician justification for the decline of a GDR for the Zoloft.

On 1/14/16, at 1:16 p.m., the consultant pharmacist (CP)-C stated he would expect a gradual dose reduction to be attempted unless there is clinical rationale documented why a dose reduction was not attempted. CP-C stated he would expect rationale to be documented why the family is declining a reduction, an explanation/reason from the past.

The facility policy Consultant Pharmacist services Provider requirements, dated 2/15, indicated the consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 30 the facility. In collaboration with the facility staff, the consultant pharmacist helps to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical services. Specific activities that the consultant pharmacist performs includes, but is not limited to: 2) communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues at least monthly.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		2/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 31 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to secure controlled medications on 1 of 4 units (during medication administration. Findings Include: On 1/14/16 at 10:10 a.m. registered nurse (RN)-C prepared R151's 10 a.m. dose of oxycodone 5 mg (controlled narcotic pain medication). R151 was unavailable to receive his dose at this time. At 10:16 a.m. RN-C parked her medication cart in the hall next to room 105 and walked away of eye sight of the medication cart; leaving the oxycodone tablet unsecured on top of the medication cart. Three staff (a laundry, physical therapy, and maintenance staff) along with 2 visitors were observed to walk next to the unsecured controlled medication. At 10:22 a.m. six minutes after walking away form the cart RN-C returned to the medication cart; locked the oxycodone inside the medication cart. At 10:40 a.m. RN-C stated, "I know that wasn't secured and it should be locked even if it is not a	F 431	Medications are secured and monitored at all times. Medications are biologics are locked in resident□s rooms, and only the primary nurse on the unit has access to the medications. Narcotics are double locked in the Medication room and require two people to sign out narcotic medications. Medications must be locked up or administered immediately upon setting it up. If the medication should only be set up when resident is available to take medication and never left unattended. Staff member involved was educated by the Nurse Educator, and understood the implications involved with leaving medication unattended. Audit will be done by Nurse Manager 3 times a week to make sure that the medication is not unattended and immediately provide education to staff if she discovers any unattended medication. Report will be provided to the Director of Clinical Manger as to compliance. Compliance will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 32 controlled med. When I remembered I did lock it up." On 1/14/16 at 1:40 p.m. the consultant pharmacist for the facility stated, "They should hold on to it[controlled medication] until they administer it and not leave it unattended." On 1/14/16 at 2:05 p.m. the director of nursing described the process for administering a controlled medication, "two nurses go in and sign it out, double check orders, five rights and do the counts for the controlled meds, set it up, identify the resident, give to the resident and observe them consuming. Should not leave the nurses hands." Facility policy, Specific Medication Administration Procedures, Medication Administration-General Guidelines, dated February 2015, page 88 reads "16. During administration of medications, the medication cart is kept closed and locked when of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by..."	F 431	achieved by February 19th, 2016.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		2/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 33 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow physician treatment orders for 1 of 3 residents (R44) reviewed for pressure ulcers. Findings include:	F 441	We have an active Infection Control committee which has participants from various units, and meets with the Quality Committee monthly. The Infection Control monitors infections, such as UTI, antibiotic usage, educates staff on precautions. Staff has been educated on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 On 1/13/16, at 6:20 a.m., licensed practical nurse (LPN)-B was observed to enter R44's room and prep R44 for wound dressing change. R44 laid in bed. LPN-B placed actic acid into a cup and distilled water into a cup. LPN-B with bare hands placed 4 x 4 gauze pads into the cups to soak. LPN-B then opened a package of acticoat 7 (nanocrystalline coating of pure silver) and cut the acticoat 7 with scissors. LPN-B stated the acticoat 7 would be soaked in distilled water then placed on the wound bases of R44's heels. LPN-B failed to wash hands and don gloves prior to handling the 4 x 4 gauze pads and the acticoat 7. LPN-B then with bare hands moved a waste basket to the bedside, removed R44's lamb wool boots, gripper socks, stockinet, applied gloves, removed tubigrips (tubular bandage) and removed comprilan wraps (100 percent cotton short stretch bandage) from R44's bilateral lower extremities. LPN-B then used scissors to cut the old dressing on both of R44's feet. LPN-B with the same gloves on, removed the old dressing from R44's right heel wound, touching the wound area and then with the same gloves on removed the dressing from R44's left heel wound, touching the wound area. The old dressings from both heels had visible drainage. LPN-B then removed gloves and applied clean gloves but failed to perform hand hygiene before donning new gloves. LPN-B then obtained the soaked acetic acid 4 x 4's and held the soaked 4 x 4's on both heels. LPN-B then removed the pads, removed gloves, applied clean gloves, obtained the soaked distilled water 4 x 4 pads and cleansed both wounds of R44's heels. LPN-B then with the	F 441	hand washing, process of gloving, isolation, clean and sterile dressing changes. The expectation of all staff when providing care to residents is that they would follow the policy of Standard Precautions in Infection Control. Education was provided immediately to LPN after discussion with the survey team, and also a return demonstration was completed by the Nurse Educator. Audit will be done by Nurse Manager 3 times a week to make sure that infection control processes are done correctly and immediately provide education to staff if there is a breach of handwashing. Report will be provided to the Director of Clinical Manger as to compliance. Compliance will be achieved by February 19th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 35	F 441		

same gloves on placed the acticaot 7 into distilled water containing 4 x 4 gauze pads. LPN-B then wrung out the 4 x 4 pads, placed the soaked acticaot 7 onto the top of the 4 x 4 pad and placed the dressing of the soaked 4 x 4 and acticoat 7 onto each wound. LPN-B then applied dry 4 x 4 pads over each heel, wrapped each heel with gauze wrap, removed gloves and secured the gauze wrap with tape. LPN-B then proceed to finish applying the ordered treatment coverings (compression wraps, stockinet, tubigrips), repositioned R44 in bed and put away supplies.

LPN-B failed to remove gloves and wash hands after cleansing each wound and after completing the dressing change.

01/13/16 at 7:13 a.m., LPN-B verified she failed to wash hands, change gloves and don gloves as noted above.

On 01/13/2016, at 7:22 a.m., the director of nursing (DON) stated she would expect staff to wash hands before starting a dressing change, after old dressing removed, remove gloves, wash hands and don clean gloves. DON stated she would expect staff to change the dressing one wound at a times to avoid cross contamination.

The facility policy Dressings, Dry/Clean, dated 8/14, indicated position the resident and adjust clothing to provide access to the affected area. Wash and dry your hands thoroughly. Put on clean gloves, loosen tape, remove soiled dressing, pull glove over dressing and discard into plastic bag, wash and dry your hands thoroughly. Put on clean gloves, cleans the wound with ordered cleanser, use dry gauze to pat the wound dry, wash and dry your hands

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 36 thoroughly. Apply clean gloves, apply the ordered dressing and secure with tape. Remove gloves and wash and dry your hands thoroughly. Reposition the bed covers and make the resident comfortable.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**01/12/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this initial survey, KODA Living Community was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/05/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**01/12/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. KODA Living Community is a 1-story building with no basement. The original building was constructed in 2013 and was determined to be of Type V (111) construction. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection in the corridors, spaces open to the corridors, and all residents sleep rooms that is monitored for automatic fire department notification. The facility has a capacity of 79 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in	K 011		2/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**01/12/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	Continued From page 2 corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 18.1.1.4, 18.1.2.3 and 8.2.3.2. The deficient practice could affect 30 out of 62 residents. Findings include: On facility tour between 9:00 AM and 12:00 noon on 01/12/2016, observation revealed, the 2 hour fire separation self closing door between Koda Living Community and Hospital, did not latch into the door frame when closed. This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 011	Both 2 hour fire doors have been repaired and do now latch as they should, they were repaired 1-13-16. The receiver latch catch had shifted because of the building settling and just needed some adjustment. It has been corrected and these doors will be monitored from now on to ensure proper operation.	
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed.	K 021		2/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**01/12/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021	Continued From page 3 18.2.2.2.6 7.2.1.8.2 This STANDARD is not met as evidenced by: Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 18.2.2.2.6 7.2.1.8.2 Findings include: On facility tour between 9:00 AM and 12:00 noon on 01/12/2016, observation revealed, the following Hazardous Area Doors were observed with kick down hold open devices: a.) Waste Collection Room #537 b.) Storage Entry Door c.) Door on Room 521 d.) Door on Room 542 This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery. NOTE: The entire Facility should be checked to	K 021	The kick down hold open devices have been removed from a, b, c, and d listed in observations. In addition, the entire building has been checked to ensure there are not any doors remaining within KODA that have kick down hold open devices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**01/12/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021	Continued From page 4 ensure no other kick down hold open devices are installed on doors intended to be self-closing.	K 021		