DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 25, 2023

Administrator
Koda Living Community
2255 30th Street Nw
Owatonna, MN 55060

RE: CCN: 245426
Cycle Start Date: August 3, 2023

Dear Administrator:

On October 20, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2023

Administrator
Koda Living Community
2255 30th Street Nw
Owatonna, MN 55060

RE: CCN: 245426
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 3, 2023, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 November 3, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by February 3, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	08/03/2023

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 On 7/31/23 to 8/3/23, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F 565		9/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2023

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

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F 565	Continued From page 1 requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act promptly and respond timely to concerns raised at resident council meetings for 5 of 10 residents, (R11, R50, R25, R6, R26) who attended council meetings. Findings include: The last twelve months of resident council minutes were requested. Minutes from 4/18/22 to 5/18/23, were received, indicating a total of seven meetings had occurred over the span of 15 months. Minutes reflected residents raised concerns, but those concerns were not followed up on at the next meeting. The minutes did not reflect who at the facility would be responsible for follow up on a particular concern.	F 565	" Interviews were completed with R11, R50, R25, and R6 to identify any current concerns. Identified concerns were entered into the Facility Grievance-Customer Concern Database to prompt and track follow-up completion. " R26 no longer resides in the facility. " Resident interviews were completed to identify additional residents with concerns and/or grievances. " Following Resident Council meetings, Interdisciplinary team meeting will be held to aid in identification and resolution of resident concerns. These concerns and	

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F 565	Continued From page 2 During a resident council meeting on 8/3/23 from 10:10 a.m. to 10:45 a.m., R50 whose quarterly Minimum Data Set (MDS) assessment dated 5/17/23, indicated intact cognition, stated the resident council met irregularly. R6 whose quarterly MDS assessment dated 7/26/23, indicated intact cognition, added meetings were not well attended, but when the ombudsman attended a meeting a few months ago, leadership attended,, adding leadership rarely attended resident council meetings. R25 whose annual MDS assessment dated 6/28/23, indicated moderately impaired cognition, stated staff did not follow up on concerns raised at resident council meetings by either providing resolution or a reason why it could not be resolved. R50 stated staff did not come back with anything concrete; they always say, "We're working on it," or, "That's the way it is." R50 stated continuity of care was a big problem; they did not get the same care every day as it was dependent upon which staff were working. R6 stated agency nursing assistants (NA's) were coming in from all over; sometimes staff even changed every few hours. R6 stated he did not feel anyone had oversight over agency staff to hold them accountable for providing care. R50 stated if the facility would take regular staff and keep them on the unit they were most familiar with, most of the problems would go away. R50 stated the facility scheduled staff on one unit one day and on another unit the next day, adding that impacted the quality of the care they received.	F 565	interventions will be recorded in the resident council meeting minutes and placed in the facility Customer Concern Database. " Audits of the resident council meeting minutes will be done monthly for 6 months to ensure resident concerns were addressed and the results were reported to the residents. Audit findings will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met	

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F 565	Continued From page 3 R6 and R26 whose annual MDS assessment dated 7/19/23, indicated intact cognition, stated they were aware which staff were agency and did not always feel confident in their ability. R26 stated sometimes he got someone who knew what they were doing and other times not. R26 stated he feared no one would come to help him. R11 whose quarterly MDS assessment dated 5/3/23, indicated intact cognition, stated she feared waking up in the middle of the night with a diabetic reaction and no one coming to help her. R50, R6 and R26 acknowledged they often had to tell staff how to do their cares - this applied to both employed staff and agency staff. R50 stated an agency NA said to him, "I'm sorry but no one has showed me how to do this" [change his brief], and stated the NA turned him back and forth 10 times before she got it right. R6 stated he and other residents have had to tell agency and employed staff who a particular resident was when a nurse was looking for a resident to administer medications, adding if staff did not regularly work on a unit, they did not know the residents. R11 stated maybe residents needed to wear name tags. R6 stated residents often waited more than 20 minutes for their call light to be answered, then staff would come in and shut the call light off, saying they would be back, but didn't come back. R50 stated if staff had time to shut off his call light, they had time to help him. R6 stated he wanted his call light left on so staff wouldn't forget about him. Residents responded yes or shook their heads affirmatively that these concerns were not new and had been expressed at past resident council	F 565		

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F 565	Continued From page 4 meetings. During an interview on 8/3/23 at 11:27 a.m., social services designee (SSD)-A stated he was responsible for resident council meetings and was new to the role. SSD-A stated he had been working with resident council to establish the frequency of meetings. SSD-A stated if residents brought up concerns, he informed a nurse manager or he might bring it up at a daily leadership meeting. SSD-A stated department managers did not attend resident council meetings, therefore he relayed resident concerns to them. SSD-A admitted the concerns, especially regarding nursing care could get lost in translation since he did not have a clinical background. SSD-A acknowledged resident concerns expressed at a resident council meeting had not been followed up at the next meeting. SSD-A acknowledged that would be important to residents. Minutes from 3/9/23, council meeting indicated: - Agency staff need to be familiar with individual care plans. Need to be familiar with equipment that is needing to be used. - Belt [transfer] not being used when transferring. - Resident shared that some personalities of staff were rough. - Asked about expectations of night shift staff; is the nurse supposed to help with cares? Not consistent for repositioning help. - What is the prospects on funding for NA's? Minutes indicated direction was given to leaders to follow up on individual resident concerns/questions/suggestions. No follow up was noted in minutes at the next meeting. Minutes from 4/6/23, council meeting indicated:	F 565		

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F 565	Continued From page 5 - They take residents out too early for the noon meal; has to wait an hour at the table before getting her meal. - They don't give us silver knives and it would be nice to have them. Right now I have to wait for someone to cut my food. - They don't come when I press my call light. I have to scream and yell to get someone. This happens daily. - We are always fed last at our table. It would be nice if we could be fed first every other meal. - More card games. No follow up was noted in the minutes at the next meeting. Minutes from 5/18/23, council meeting indicated: -- A resident asked about morning appointments, and how to get to those on time with new meal times. -- When staff have last minute call-ins, it puts residents in a bad situation. -- I want to get up and do stuff myself, but I get bawled out when I don't ask for help or someone sees me doing it by myself. The May meeting concerns had not been addressed, two months later. During an interview on 8/3/23 at 3:23 p.m., the director of nursing (DON) was informed of concerns identified at the resident council meeting regarding lack of follow up. The DON who did not attend resident council meetings was informed residents stated they wanted someone to listen to them who understood and could resolve their issues. The DON stated she did not attend resident council meetings because she wanted residents to be able to speak freely.	F 565		

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F 565	Continued From page 6 During an interview on 8/3/23 at 3:28 p.m., the administrator was informed of concerns identified at the resident council meeting regarding lack of follow up. The administrator stated any grievances brought to her attention were addressed and fixed. A complaint identified by R50 at the resident council meeting was noted on the grievance log and indicated: R50 expressed concern regarding two issues: 1) Continuity of care; felt like there was lack of continuous stable staff responsible for care. New care givers who had not learned his routine, leaving him feeling he had to teach new staff over and over again how to care for him. 2) Distribution of experienced staff within the building, e.g., inexperienced staff working on the heavier units. The findings and resolution identified on the grievance log included: The facility does not have control over the consistency of pool staff to cover open shifts. The resident care level needs of the four units are not dissimilar. Covering open shifts involves assigning available personnel to the areas where they are needed. The root cause of R50's concern was not addressed; the response did not address R50's concern about his care and having to teach new staff over and over again. The administrator acknowledged leadership staff did not regularly attend resident council meetings and would only attend if residents wanted that. The administrator did not know if residents had been asked if they wanted leadership staff to attend some or all meetings. The facility Resident Council policy dated 11/28/17, indicated the purpose was to provide for resident groups to meet and to provide a forum for facility's management to listen to and respond to resident ideas and concerns. When a resident group existed, the facility listened to resident	F 565		

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F 565	Continued From page 7 group views, and acted upon the concerns and recommendations of residents. The facility seriously considered the group's recommendations and attempted to accommodate those recommendations, to the extent practicable, in developing and changing facility policies affecting resident care and life in the facility. The facility communicated its decisions to the resident group.	F 565		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions to prevent potential worsening of contractures for 1 of 2 residents (R17) reviewed for contractures.	F 688	• OT evaluation was completed for R17 to determine the appropriateness of the hand splint. Care plan was reviewed and updated to reflect OT findings. • Care plans were reviewed and	9/19/23

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F 688	Continued From page 8 Findings include: R17's diagnoses located on the physician order sheet dated 7/14/23, included: cerebral infarction (obstructive blood flow to the brain), unspecified hemiplegia (paralysis of partial or total body function on one side of the body) and physical debility (state of general weakness). R17's quarterly Minimum Data Set (MDS) assessment dated 6/14/23, indicated severely impaired cognition. R17 required extensive assist with activities of daily living (ADL's) that included personal cares. The MDS identified R17 as having impairment of range of motion (ROM) on both sides of the upper and lower extremeties. R17's current care plan reviewed on 6/29/23, identified R17 as having skin alteration and poor tissue integrity related to impaired mobility, diabetes, stroke and hand contractures. The care plan identified contractures of the left hand. The right hand 3rd, 4th and 5th fingers unable to fully extend at variable joints. The care plan further indicated R17 was at risk for additional contractures. Interventions included: apply blue hand splint at night to the left hand, palm protectors to both hands during the day, PROM to upper extremeties daily, cue resident to extend at variable joints if noted to be clenching the hand, report any changes to the charge nurse and occupational therapy (OT) and report skin breakdown. Review of the most current OT notes dated 11/3/20, directed the staff to apply a splints to R17's left and right hand at night and palm protectors to both hands during the day when not participating in ADL's.	F 688	updated as necessary for all resident's utilizing adaptive devices. • All nursing staff will be educated on adaptive devices; including demonstration of donning devices correctly. • Audits will be completed by the DON or designee weekly for 4 weeks for compliance of proper use of adaptive devices. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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F 688	Continued From page 9 On 7/31/23 at 4:12 p.m. R17 was observed to have both hands/fingers clenched tightly to the palm of the hand. When R17 was asked if able to open her hands, she was unable to open her right hand and only able to slightly open her 3rd and 4th fingers of the left hand. Observations on 8/1/23 from 9:00 a.m. to 3:30 p.m., R17's left hand/fingers were tightly clenched to the palm of her hand. R17 was unable to open her left hand when asked. R17 only had a palm protector in the right hand. Observations on 8/2/23 from 7:30 a.m. to 2:30 p.m., R17 noted to have both hands/fingers clenched tightly to the palm of her hand. R17 did not have palm protectors in either hand . R17 was unable to open either of her hands when asked. Observations on 8/3/23, from 11:00 a.m. to 3:00 p.m. R17 again noted to have both hands/fingers clenched tightly to the palm of her hand. R17 did not have palm protectors in either hand . R17 was unable to open her hands when asked. Nursing assistant (NA)-H manually assisted R17 with opening her hands and fingers, but could only open both hands slightly with resistance. R17's palms of both hands noted to be moist and slightly pink, where the fingers were tightly clenched to the palm of the hand. Interview on 8/2/23 at 9:00 a.m. NA-H and NA-I indicated they were both aware of the palm protectors for R17's hand contractures, but indicated the staff did not always have time to implement the treatment. NA-H and NA-I indicated staff try and do passive range of motion (PROM) to R17's hands when dressing her in the	F 688		

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F 688	Continued From page 10 morning, but verified this had not been done this morning. Interview on 8/3/23 at 11:30 a.m. NA-H confirmed R17 should have hand rolls placed in both of her hands each day. NA-H indicated this should have been done when getting R27 up for the day, but had not been implemented. Interview on 8/3/23 at 4:00 p.m. the director of nursing (DON) indicated she had not been aware of the staff not implementing the prescribed treatment to R17's hands/contractures, and further confirmed it should have been done each day as ordered. A policy for contractures was requested, but not provided.	F 688		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726		9/19/23

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F 726	Continued From page 11 assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure agency nursing assistants (NA's) received appropriate orientation and training prior to starting their first shift caring for residents. This had the potential to affect all 78 residents residing in the facility. Findings include: During an interview on 8/2/23 at 07:21 a.m., (NA)-A stated the facility used a lot of agency nursing staff including NA's. NA-A stated at times, there were more agency staff on duty than employed staff. NA-A stated the weekend of 7/29/23 to 7/30/23, on the 2:00 p.m. to 10:00 p.m., two new agency NA's started: (NA)-C and (NA)-D. NA-A stated they came one hour early to receive an hour of orientation before caring for residents on their own. NA-A was required to provide the one-hour orientation while also caring for 17 residents on the unit. NA-A stated one hour was not enough time to show and explain everything to an agency NA before their shift. Further, NA-A stated NA-C had told her she was	F 726	• No identified residents were affected in this incident. • Resident interviews were conducted regarding staff knowledge related to facility lifts. • Facility's process was reviewed and revised regarding onboarding agency nursing assistants. A competency checklist will be implemented for agency nursing assistants that includes the use of mechanical lifts and transfer status per the plan of care. • Facility nursing assistants providing orientation/onboarding training to agency associates will be educated on the competency checklist and asked to ensure completion prior to agency associates maneuvering lifts independently. • Competency audits will be done	

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F 726	Continued From page 12 a new NA and did not know how to use the sit-to-stand transfer aid (a piece of equipment used to raise a resident up from a bed, chair, toilet, or wheelchair to another surface). NA-A stated she had communicated her concerns to leadership in the past about the brief orientation and training that agency NA's received and was told it was the agency NA's choice to pick up the shift. During an interview on 8/2/23, at 7:31 a.m., (NA)-B who was agency staff and had worked at the facility since May 2023, stated she had never seen a residents care plan...."if there is a care plan, I've never seen it." NA-B stated if residents were able to talk, they walked her through their cares. If a resident could not talk, she did routine cares. Each resident room had a white board on the wall with information written on it such as ambulation status. NA-B stated she referred to the white board as well to determine cares for residents. During an interview on 8/2/23 at 10:53 a.m., staffing coordinator (SC)-E stated she was the nursing staff scheduler and scheduled orientation for agency NA's. SC-E stated if an agency NA contracted for a four-week assignment, he/she received eight hours of orientation. If an agency NA picked up just one shift, they were considered per diem and received one hour of orientation before the start of their shift. SC-E stated the facility had contracts with two agencies for staffing; staffing agency (SA)-H and (SA)-I. SC-E stated she thought the agency provided orientation/training for the NA before the NA arrived at the facility. To demonstrate this, SC-E was given the names of NA-C and NA-D to determine the training provided by the agency.	F 726	weekly for 6 weeks to monitor for onboarding compliance. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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F 726	Continued From page 13 SC-E pulled up documents on a computer from SA-H titled Credential Report. Both NA-C and NA-D received training on regulatory topics such as dementia, bill of rights, abuse, blood borne pathogens and HIPAA. There had been no training listed for equipment. SC-E stated no one from the facility looked at agency NA profiles before the NA arrived for duty, stating she assumed SA-H sent qualified individuals. SC-E stated she posted open shifts on SA-H's website, the agency filled the shift and the NA reported to work. SC-E stated agency NA's were given a welcome letter and a password for access to the electronic medical record (EMR), but no other paperwork such as an orientation checklist was provided. Documentation of equipment training for NA-C and NA-D provided by the SA had been requested. The director of nursing (DON) provided documentation of regulatory training, such as abuse, infection control, dementia and Alzheimer's training, but no equipment training. Further, the DON was asked for documentation of orientation and training provided by the facility for NA-C and NA-D. The DON provided blank copies of orientation and training documents the facility was in the process of developing for agency staff but had not yet implemented. The DON was asked for copies of facility agreements with SA-H and SA-I. The staffing agreement with SA-H signed 11/17/22, indicated the facility would orientate HCP (healthcare professional) to its facility, including its rules, regulations, policies, procedures, physical layout, emergency protocol, emergency evacuation and equipment on any unit to which the HCP is assigned. The agreement with SA-I signed 2/21/17 did not include language about clinical competency and/or equipment	F 726		

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F 726	Continued From page 14 training. During an interview on 8/03/23 at 9:27 a.m., the DON stated it was her expectation that agency NA's were competent in NA duties, had a certain skill set and knew how to do transfers with equipment. The DON stated NA's had a certificate and she assumed had experience with a sit-to-stand transfer aid and mechanical lift. The DON stated per diem NA's arrived an hour early for orientation and followed an employed NA around for that hour. The DON stated the agency NA was shown the layout of facility, where things were located and were introduced to the residents they would care for. The DON admitted the facility NA who provided the orientation did not follow a guideline or checklist to ensure all expectations were covered, nor did the facility document the orientation provided to the agency NA. The DON stated she worked with SC-E on the nursing staff schedule and was aware the facility utilized a significant number of agency staff. The DON stated sometimes it was all agency staff who were assigned to a unit, adding that was not preferred, but sometimes they were the only nurses and NA's available. On 8/3/23 at 9:40 a.m., the administrator joined the conversation with the DON and stated she had not been aware agencies did not provide documentation of equipment training. The DON interjected she was going to contact SA-H for that information as she assumed SA-H provided equipment training. The administrator stated she had recently met with facility NA's to outline expectations when assigned to orientate agency NA's. A copy of this document, titled Orientation for our agency support staff, read in part: You may be asked to provide a one-hour orientation to	F 726		

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F 726	Continued From page 15 our agency support staff. Please use this as a guide to help you with the process. 1. Welcome them to the facility. We are glad you are here to support our excellent care. We care for some of the most vulnerable residents in the county. Introduce yourself. 2. Ask them about their experience as a CNA (certified nursing assistant). This shows interest in them and also give you and idea of their overall knowledge base. 3. Provide a short tour of the building...bathrooms, breakroom, parking. 4. Make certain they have a nametag. 5. In the neighborhood where they will be working, introduce them to staff. Provide a tour. Show and explain items they will need to know....linen, briefs, garbage, dirty linen, supplies, CNA care sheets, explain information about the residents in your neighborhood. Walk them through charting in POC (point of care in EMR). Set them up with a radio and show them how it works. Explain process for shift-to-shift changeover. Ask them if they have questions. This orientation guide did not ensure an agency NA knew how to, or was trained in, the use of the facility's lift equipment, such as a sit-to-stand transfer aid or a mechanical lift. During an interview on 8/3/23 at 1:56 p.m., (NA)-E stated she worked with agency NA's and stated some were well-trained and some were not. NA-E stated some had never used a sit-to-stand transfer aid or a mechanical lift so NA-E had to teach them. NA-E stated she felt NA's should already be trained when they arrived or at least be familiar with this equipment, adding she realized every lift brand was different but the concepts were similar.	F 726		

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F 726	Continued From page 16 Telephone numbers for NA-C and NA-D were requested. The DON stated the facility did not have them and provided a telephone number for SA-H to request them. On 8/3/23 at 2:39 p.m., client account manager (CCM)-F for SA-H was contacted. CCM-F stated NA-C and NA-D both went through supplier partners; therefore, he would need to ask if their telephone numbers could be provided. CCM-F stated he did not know what kind of training and orientation NA's received prior to working for client nursing homes but would check. On 8/3/23 at 3:19 p.m., the DON was informed of concerns related to agency NA's orientation and training and the obligation of the facility to ensure competent staff were caring for residents. The DON stated she agreed and assumed agencies had provided equipment training. The DON stated she had been attempting to get documentation of training conducted by the agencies for NA's. These documents were not provided by the time of exit on 8/3/23 at 6:00 p.m. The facility could not provide documentation by either the agency or by the facility ensuring agency NA's had been educated and trained on equipment such as a sit-to-stand transfer aid and mechanical lift. On 8/4/23 at 3:29 p.m., an email was received from compliance manager (CM)-G for SA-H, confirming she had been informed the facility had requested validation of lift training at the agency level. CM-G wrote: In order to ensure a smooth and efficient process, our valued clients are responsible for the orientation of all policies, procedures, and equipment, including lifts, as each site may have unique equipment	F 726		

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F 726	Continued From page 17 configurations. This expectation is in place in accordance with our Master Service Agreement. This allows our Healthcare Professionals guidance with the specific setup at the client's location which contributes to a successful and seamless working relationship. The facility policy on clinical competency of agency nursing staff was requested and not received. In an email dated 8/7/23 at 1:10 p.m., the administrator indicated the use of lifts was part of a NA's knowledge base included in the long-term care core.	F 726		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop individualized interventions to address exhibited behaviors of dementia for 1 of 1 resident (R43) observed to wander on unit and reported to go into other residents' rooms. Findings include: R43's significant change in status Minimum Data Sheet (MDS) assessment dated 7/12/23, indicated R43 had severely impaired cognition, had severely impaired vision and moderate	F 744	• Care plan for R43 updated to reflect current interventions related to individualized dementia-specific care. • All residents with a diagnosis of dementia were reviewed for specific dementia related inventions and care plans updated as necessary. • Nursing staff received education regarding dementia care and individualized dementia-specific interventions. Dementia specific care plans will be reviewed and updated quarterly with care conferences.	9/19/23

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F 744	Continued From page 18 difficulty hearing, had clear speech, sometimes understood by others, sometimes understands others, required extensive assistance of one person for all activities of daily living (ADL) needs, had an unsteady gait, used a wheelchair for mobility needs, and had frequent falls with minor injuries. The MDS further indicated R43 displayed daily behaviors including hallucinations (altered perception of reality), delusions (false beliefs), wandering, rejection of care, exhibited daily physical and verbal behaviors towards others, was taking antianxiety and antidepressant (mood) medications for mood and behavioral management. R43's face sheet, received on 8/3/23, indicated diagnoses including anxiety, pain, Alzheimer's disease (memory loss), insomnia (trouble falling and staying asleep), restlessness and agitation, dementia (memory loss and inability to make decisions), cognitive communicative deficit (inability to process understanding of language), legally blind, hard of hearing, on hospice. R43's care plan, received on 8/3/23, identified R43 had dementia and was disoriented to place, had communicative deficits and was visually impaired, was independent of wheelchair mobility, had impaired safety awareness, would display disruptive behavioral symptoms evidenced by intrusion of privacy and elopement attempts. Interventions included staff to assess R43's behaviors for endangerment to self/others and intervene if necessary, maintain calm environment, maintain a calm, slow, understandable approach, allow alone time if needed, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.), distract from wandering by offering pleasant	F 744	• Care plan audits will be completed by the DON or designee weekly for 12 weeks for residents with a diagnosis of Dementia. Audits will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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F 744	Continued From page 19 diversions, structured activities, food, conversation, television, book, document all incidents of wandering, apply an alarm for alarm doors as does wear a wander guard on wheelchair, administer medications: Lorazepam PRN (as needed)-(HOSPICE MED), monitor, record effectiveness, and report any adverse side effects. R43's behavioral assessment, completed on 7/12/23, indicated R43 had Alzheimer's disease, anxiety disorder, and organic brain syndrome (affecting mental and cognitive abilities). R43 exhibited hallucinations and delusions, displayed physical and verbal behaviors towards others, and behaviors not directed towards others daily which affected participation in cares, social activities, privacy of others, and disruption to living environment. Behavioral assessment also indicated R43 wandered daily putting her at significant risk of getting to a dangerous place and wandering significantly intruded on privacy/activities of others. Interventions did not list non-pharmacological measures taken, pharmacological measures consisted of analgesics (pain medication) and anxiolytics (anxiety medication) which were effective in symptom management, received hospice care, and to continue current care plan in place. Nursing progress note dated 7/26/2023 at 11:31 p.m., indicated resident has been more anxious this pm. Wheeling into other residents' rooms. Difficult to re-direct. Snacks have been offered several times. Resident goes into her bed, and then is back up wheeling around the neighborhood. Nursing progress note, dated 7/07/2023 at 9:43	F 744		

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F 744	Continued From page 20	F 744		

p,m., resident attempting to leave unit multiple times. Wheeling into other residents' rooms and upsetting them. Re-directing not successful. PRN Ativan given, and resident was more calm.

While observed, on 7/31/23 at 6:42 p.m., R4 visualized in wheelchair roaming around unit hallways, stopped at entrance of a resident room, was observed talking to self, continued roaming on unit.

During record review and interview on 7/31/23 at 6:53 p.m., R20's quarterly MDS assessment, dated 5/15/23, identified R20 having intact cognition. R20 reported awareness of R43 going into resident rooms, stated R43 came into her room on 7/30/23, R43 was rummaging through her personal items and trying to use her phone, phone cord became caught on R43's wheelchair and broke phone, R43 was told by R20 to get out of room.

While interviewed on 8/01/23 at 10:04 a.m., family member (FM)-J indicated awareness R43 wanders on unit and goes into other resident rooms, stated R43 was visually impaired and believed R43 would go into other resident rooms thinking it was her room, aware staff provided redirection when R43 in other resident rooms.

During an interview on 8/02/23 at 9:22 a.m., nursing assistant (NA)-F indicated R43 would frequently go into other resident rooms, aware of other residents reporting they were bothered by R43 coming into their rooms, stated it was especially bothersome for R1. NA-F indicated staff would provide R43 with redirection when going into other residents' rooms, tried to increase supervision, would provide R43 snacks

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F 744	Continued From page 21 when more restless and wandering. While interviewed on 8/03/23 at 10:00 a.m., NA-G indicated awareness of R43 wandering into other residents' rooms, almost daily, often wandered into R1's room, stated R43 thought her room was R1's room. NA-G indicated R43 had wandered into R1's room, R1 became upset with R43, R1 told R43 to get out of room. NA-G stated on another occasion, R43 crawled into R1's bed to take a nap, R1 wanted to lie down in bed and became upset seeing R43 in her bed, R1 had to wait for staff to remove R43 from her room and change her bed sheets. NA-G indicated staff monitored R43's wandering on unit more frequently, provided redirection when R43 wandered into other residents' rooms. During an interview on 8/03/23 at 10:42 a.m., licensed practical nurse (LPN)-C indicated awareness of R43 wandering into other residents' rooms, stated R43 would go into R7's room and watch TV. LPN-C indicated R43 would go into R1's room, thought R1's room was her room, stated awareness R1 was bothered by R43 being in her room. LPN-C indicated staff provided redirection when R43 wandered into other residents' rooms, staff placed a sign on R43's door to remind her of her room, stated R43 could not see sign very well due to visual impairment. LPN-C indicated interventions in place at time had not prevented R43 from wandering into other residents' rooms and further prevention measures were needed. While interviewed on 8/3/23 at 3:30 p.m., LPN-D indicated awareness of R43 wandering into other resident's rooms, specifically R1's room, stated R43 liked R1's soft fuzzy blanket she had in	F 744		

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	245426	A. BUILDING _____ B. WING _____	08/03/2023

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F 744	Continued From page 22 room. LPN-D indicated staff provided R43 with same type of soft fuzzy blanket R1 had approx. 2 weeks ago, unaware of R43 going into R1's room since provided blanket. LPN-D stated staff tried to prevent R43 from wandering into other residents' rooms by offering music and activities she enjoyed and providing increased supervision. During an interview on 8/3/23 at 3:59 p.m., the director of nursing (DON) indicated awareness of R43 wandering into other residents' rooms, last wandering episode aware of was approx. 1 month ago. The DON stated staff provided redirection, increased supervision, interaction with activities to reduce wandering behaviors. The DON indicated it was her expectation for staff to notify her if R43 continued to wander into other residents' rooms to discuss further preventative measures. The facility Elopement policy revised 10/14/22, consisted of; to maintain the safety of residents who are at risk of wandering, associates will engage in interventions to prevent wandering, the nurse or social services will evaluate each resident's potential for wandering upon admission and as needed, the nurse or social services identifies necessary interventions for each resident in their care plan, assessment, and/or abuse prevention plan.	F 744		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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	F 761		9/19/23

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F 761	Continued From page 23 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were securely stored, permitting only authorized personnel to have access for 4 of 4 residents (R62, R28, R37, R172) reviewed for medication storage. This had the potential to affect residents, visitors and staff who had access to the resident rooms. Findings include: Each resident at the facility had a wooden medication storage cupboard attached to a wall in their room. Each cupboard had a keyhole affixed to it. During observations on 7/31/23 between 2:25 p.m. and 4:10 p.m., on the Kindle unit, the medication storage cupboards in R62, R28, R37	F 761	• The medication storage cabinets for R62, R28, R37, R172 were inspected to assure they were functioning properly. No repairs were needed. • The policy for medication storage was reviewed and revised to include the use of medication storage cabinets in resident's rooms. • Education provided to licensed nursing staff on the facility medication storage policy. • Audits will be done weekly by the DON or designee for 4 weeks to assure the medication cabinets in the resident rooms were secured. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through	

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F 761	Continued From page 24 and R172's rooms were noted to be unlocked with medications inside. R62's unsecured medication included: -- Timolol maleate 0.5% (for glaucoma), 1 drop both eyes once a day between 6:30 a.m. and 11:00 a.m. One bottle of drops. R28's unsecured medications included: -- Albuterol sulfate inhalation solution (for lung diseases), 2.5 milligrams (mg)/3 milliliters (ml) every six hours PRN (as needed). One box of vials. -- Pulmicort Flexhaler (for lung diseases), 90 mcg (micrograms) 2 puffs twice a day PRN. One inhaler. -- Lidoderm patch (for pain) 5%, 1 patch topical at bedtime at 8:00 p.m. Eleven patches. -- Refresh Plus eye drops (for dry eyes) 0.5% 1 gtt (drop) four times a day, both eyes, PRN. One bottle. -- Fluticasone nasal spray 1 spray both nostrils once a morning PRN. One bottle. -- Albuterol inhaler (for lung diseases) 90 mcg 1-2 puffs every 4 hours PRN. One inhaler. During an interview on 7/31/23 at 2:31 p.m., R28 stated she did not access the cupboard, and had only observed nurses access it. In addition, R28 stated she did not notice if the cupboard was usually kept locked or unlocked. R37's unsecured medications included: -- Diclofenac Sodium Topical gel (for arthritis pain) 1% 2 grams topical 4 times a day, 8:00 a.m., 12:00 a.m., 4:00 p.m., 8:00 p.m. One tube. -- Refresh Tears eye drops 0.5% 1 gtt, twice a day, 11:00 a.m., and 10:00 p.m. One bottle. -- Albuterol inhaler 90 mcg 2 puffs every 4 hours PRN. One inhaler.	F 761	analysis and review of results if substantial compliance is not met	

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F 761	Continued From page 25 R172's unsecured medication included: -- AsperFlex patches (for arthritis pain), 1 patch topical. Apply to right hip for pain once a day, 8:00 a.m. Eight patches. During an interview on 7/31/23 at 4:38 p.m., licensed practical nurse (LPN)-A stated the medication cupboard in resident rooms were supposed to be locked if there were medications inside. When informed of findings, LPN-A stated she was not aware some cupboards had been unlocked. Together with LPN-A went to each room and cupboard on the Kindle unit to determine if cupboards were secure. All cupboards were locked except for cupboards in R62, R28, R37, R172 rooms, and LPN-A locked them. LPN-A who had started her shift at 2:00 p.m., stated she had not accessed the cupboards. During an interview on 8/1/23 at 3:03 p.m., registered nurse (RN)-A who was also the nurse manager for the Kindle unit stated medication cupboards in residents rooms were expected to be locked if they had medication inside. RN-A stated she was informed of findings from 7/31/23 and would determine who accessed the cupboards on the day shift on 7/31/23. During a telephone interview on 8/2/23 at 11:56 a.m., (LPN)-B stated she had worked the 6:00 a.m. to 2:30 p.m., shift on 7/31/23 on the Kindle unit and had been made aware by the facility that some resident medication cupboards had been found unlocked following her shift. LPN-B stated she did not recall leaving any cupboards unlocked. LPN-B could not recall which cupboards she accessed on 7/31/23 other than	F 761		

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F 761	Continued From page 26 R62's to obtain eye drops. LPN-B stated she knew all medications should be secured to prevent unauthorized access. During an interview on 8/3/23 at 2:56 p.m., the director of nursing (DON) stated she was aware medication storage cupboards on Kindle unit were found unlocked on 7/31/23. The DON stated if medication were in a cupboard, the cupboard was expected to be locked when not in use. The DON stated it was part of training for nurses, including agency nurses. The facility Storage of Medications policy dated 2001, indicated compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals would be locked when not in use, and items would not be left unattended when open and potentially available to others.	F 761		

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	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**08/01/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/01/2023. At the time of this survey, KODA LIVING COMMUNITY was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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 facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and	K 000		

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K 000	Continued From page 2 spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 79 beds and had a census of 75 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 17.14.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/01/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that the manual fire alarm pull-station located in the Kitchen was access obstructed.	K 345	The area in front of one manual fire alarm pull-station in the kitchen was immediately addressed by moving the wheeled cart that was in front of the pull-station. Shelving in the same hallway was rearranged to have our wheeled carts in a different location. Black and yellow caution tape was added to the floor area immediately in front of the pull station to remind all associates of this being barrier free zone. Education was completed with culinary associates by August 4, 2032 explaining that this pull-station area cannot be blocked at any time. Culinary director and supervisor will	9/19/23

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K 345	Continued From page 3 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	continue to educate new associates as hired. Random audits will be conducted one time each week for 2 months to ensure that no item is blocking access to this pull-station. Audits will be conducted by Culinary director or designee.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of	K 353	Facility TELS system has been reviewed and set up to reflect requirements for quarterly testing and annual testing. Scheduling has already taken place for next year as well.	9/19/23

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K 353	Continued From page 4 Water-Based Fire Protection Systems, section(s), 4.1.1.1.1, 4.1.1.2, 4.3, 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/01/2023 between 10:00 AM and 2:00 PM, it was revealed by a review of available documentation, that there was no documentation was presented to confirm that the fire sprinkler system received a quarterly inspection in Q3 of 2022 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	Environmental Services Director has reviewed systems in place for accuracy and this was completed by August 23,2023.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1 This deficient finding could have an isolated impact on the residents within the facility.	K 355	An area in facility main kitchen which housed a fire extinguisher was cleared for proper access. This was completes by August 4, 2023. Black and yellow caution tape was added to the floor area immediately in front of the fire extinguisher to remind all associates of this being a barrier free zone. Education was completed with culinary associates by August 4,2023 and ongoing education will	9/19/23

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K 355	Continued From page 5 Findings include: On 08/01/2023 between 10:00 AM and 2:00 PM, it was revealed by observation, that the fire extinguisher located in the Kitchen was access obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	continue with all new associates. Random audits will be conducted one time per week for two months by facility culinary director or designee to ensure this area is accessible.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 374	The Dawn neighborhood main door (smoke barrier) was inspected and adjusted for proper air gap measurements of less than 1/8 inch. This conducted by August 2, 2023. All smoke barriers doors in the facility were inspected by August 11, 2023.	9/19/23

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K 374	Continued From page 6 On 08/01/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that Dawn Wing smoke barrier doors exhibited an air gap greater than 1/8 inch An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		10/16/23

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 _____	**08/01/2023**

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

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K 918	Continued From page 7 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.17 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 5.6.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/01/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that the generator remote annunciator panel was found to be located in a remote area not readily able to be monitored, observed, responded to by staff An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	The facility generator remote annunciator panel has been in a small office since this building opened in 2013. A facility vendor has been consulted and plans are in place to move the facility generator remote annunciator to the Aspen Nurse office where it will be accessible by associates 24 hours a day/7 days a week, thus being monitored, observed and responded to by associates as appropriate. Facility Environmental Service Director is responsible for completed work and education. Vendor timeframe for completion is set for October 16, 2023.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.	K 923		9/19/23

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	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**08/01/2023**

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

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K 923	Continued From page 8 >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 5.1.3.3.2 (7), 11.6.2.3 (11). These deficient findings could have a widespread impact on the	K 923	In the facility Medical Gas (oxygen) storage rooms, all free-standing cylinders were removed on August 3,2023. Facility also added three storage racks to hold all oxygen cylinders. The medical gas storage room door handle was updated,	

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	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**08/01/2023**

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KODA LIVING COMMUNITY	**2255 30TH STREET NW OWATONNA, MN 55060**

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K 923	Continued From page 9 residents within the facility. Findings include: 1. On 08/01/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that in the Med Gas (O2) Storage Rooms there were free-standing cylinders. 2. On 08/01/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that in the Med Gas (O2) Storage Rooms door was found to be unsecured. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	and lock was added to ensure a secure door. Education regarding proper storage of cylinders and the task of locking the medical gas storage room door was provided to associates on August 31, 2023 and September 6-7, 2023.	