DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2022

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

RE: CCN: 245426
Cycle Start Date: March 10, 2022

Dear Administrator:

On March 23, 2022, we notified you a remedy was imposed. On April 19, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 4, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 7, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 23, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 7, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 4, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2022

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

Re: Reinspection Results
Event ID: VC6212

Dear Administrator:

On April 19, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 10, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any 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

DEPARTMENT OF HEALTH

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Electronically delivered
June 17, 2022

CMS Certification Number (CCN): 245426

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

Dear Administrator:

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 April 4, 2022 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any 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

Electronically delivered
March 23, 2022

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

RE: CCN: 245426
Cycle Start Date: March 10, 2022

Dear Administrator:

On March 10, 2022, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 7, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 7, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 7, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 7, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Koda Living Community will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 7, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 September 10, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to

file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
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 _____	C 03/10/2022

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
E 000	Initial Comments On 3/7/22 to 3/10/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/7/22 - 3/10/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H5426057C (MN81219), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaint was found to be UNSUBSTANTIATED: H5426058C (MN80635). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

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

Electronically Signed | 03/29/2022

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 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration for 4 of 4 residents (R7, R18, R32, R46) observed to receive medications during breakfast. Findings include: R18's face sheet printed 3/9/21, identified R18 was admitted 9/2020 and diagnoses included dementia, Alzheimer's, type 2 diabetes, and constipation. R18's quarterly Minimum Data Set (MDS) assessment dated 12/15/21, indicated severe cognitive impairment and extensive assist with toilet use, personal hygiene, dressing, and transfers. R18's care plan dated 2/9/22, indicated R18 was at risk for pain and interventions included administer medications as ordered and monitor effectiveness and keep MD/NP aware of. R18's physician order report printed 3/9/22,	F 658	SPECIFIC RESIDENTS: Resident R18, R46, R32 and R7 affected by the alleged deficient practice remain in the facility. No negative effects occurred from the alleged practice. LPN was immediately educated on best practice of medication set up, administration and documentation. LPN understood all education given and demonstrated understanding. OTHER RESIDENTS: For all residents within facility that require medication administration licensed nurses will follow best practice on medication set up and administration. Licensed nurses will be educated that the policy for Benedictine is that we do not pre-set up medications. Director of Nursing or designee will educate the procedure for licensed associates on best practice for medication set up, administration and documentation by April 4, 2022. MONITOR: The Director of Nursing or Designee will audit the medication cart for	4/4/22

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F 658	Continued From page 2 indicated acetaminophen (pain reliever) tablet 650 mg oral four times a day, atenolol tablet (lowers blood pressure) 50 mg once a morning and Senna plus (constipation medication) 8.6-50 mg 2 tabs oral, with special Instructions: hold dose if loose stool twice a day, and may crush medications and administer together with applesauce or pudding. R46 R46 face sheet printed 3/9/21, identified R46 was admitted 6/2017 and diagnoses included dementia, Parkinson's disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement) schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), anxiety, and seizures. R46's quarterly MDS assessment dated 2/2/22, indicated severe cognitive impairment, dependent on staff for transfers, and extensive assist with toilet use, personal hygiene, and dressing. R46's care plan dated 1/30/22, indicated R46 had chosen not to self-administer meds on admit, currently unable to physically or cognitively self-administer, will receive medications as ordered, by nursing staff. Crushed meds: nursing staff will administer meds as ordered by MD/NP. Resident prefers meds crushed. Okay to crush meds, mix and give with food d/t (due to) diagnosis of dysphagia, give with pudding thick liquids. Resident was at risk for pain and interventions included administer medications as ordered and monitor effectiveness and keep MD/NP aware of.	F 658	pre-set up medications eight times a week for the first four weeks to assure no pre-set up is occurring. Then audit the medication cart for pre-set up medications four times weekly for two weeks. Results will be provided to Quality Council.	

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F 658	Continued From page 3 R46's physician order report printed 3/9/22, indicated Acetaminophen Extra Strength tablet 1000 mg oral three times a day, donepezil (medication for dementia) tablet 10 mg oral daily special instructions: side effects nausea, vomiting, and diarrhea, and okay to crush meds, mix and give with food d/t diagnosis of dysphagia, need for spoon thick liquids, and resident request for pills to be crushed as she has difficulty swallowing pills whole. R32 R32's face sheet printed 3/9/21, identified R32 was admitted 9/2021, and diagnoses included psychosis (an abnormal condition of the brain that results in difficulties determining what is real and what is not real) , depression, weakness, disorientation, constipation, chronic pain, and anxiety, R32's quarterly MDS assessment dated 1/19/22, indicated moderate cognitive impairment and extensive assist with toilet use, personal hygiene, dressing, and transfers. R32's care plan, dated 1/18/22, indicated resident is at risk for pain r/t chronic pain administer medications as ordered. currently has scheduled and prn analgesic and monitor effectiveness and keep md/np aware of concerns. R32's physician order report printed 3/9/22, indicated quetiapine (med for psychosis) 100 mg oral twice a day, sennosides-docusate sodium (medication for constipation) 8.6-50 mg 2 tabs oral special instructions: hold if stools are loose twice a day R7	F 658		

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F 658	Continued From page 4 R7's face sheet printed 3/9/21, identified R7 admitted 6/2018, and diagnoses included dementia, disorientation, muscle weakness, and pain. R7's quarterly MDS assessment dated 2/23/22, indicated severe cognitive impairment and dependent on staff for dressing, eating, toilet use, transfers and personal hygiene. R7's care plan, dated 2/22/22, indicated R7 had a history of pain, given dementia she is unable to communicate pain, Staff observe for non-verbal signs of pain and treat per orders. Receives Scheduled Tylenol. Administer medications as prescribed by provider. Notify CNP/MD of increased s/s of pain, uncontrolled pain. R7's physician order report printed 3/9/22, indicated acetaminophen 500 mg oral tablet three times a day and memantine (dementia mediation) 100 mg; oral tablet twice a day. On 3/9/22, at 7:52 a.m. licensed practical nurse (LPN)-D was observed with 4 clear medication cups and the cups contained either crushed and /or whole pills and each cup was labeled respectively with a J, B, M, and R. LPN-D indicated he had just finished setting up the residents' medications and labeled the medication cups with the first initial of the resident's name. LPN-A was observed to place three of the medication cups into the top drawer of the medication cart, lock the cart and administer crushed medications to unknown resident. LPN-A indicated if the medications spilled out of the cup, or the crushed medication cup tipped over in the medication cart he would dispose of the meds and start over with med	F 658		

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F 658	Continued From page 5	F 658		

administration. LPN-D confirmed the medications pre-set up in the top drawer of the medication cart was not best practice and was not his usual practice, but the residents were ready for their meds at the breakfast table and wanted to give the medications timely.

On 3/9/22, at 8:00 a.m. registered nurse (RN)-A stated medications were not expected to be preset up in medications cup, and not administered to the resident immediately. RN-A further indicated medications were not to be stored in the med cup in the med cart drawer set up. RN-A further indicated the meds could spill in the top drawer of the med cart and/or get misplaced in cart.

On 3/9/22 1:41 p.m. the director of nursing (DON) stated staff were expected to set up the medications in the medication cup and administer immediately, and confirmed multiple residents medications were not to be placed in medication cups and stored in the medication cart. The DON stated this was not best practice.

Policy title medication storage in the facility dated 4/1/19. indicated
-Medications and biological's are stored safely, securely, and properly, following manufacturers recommendations or those of the supplier.
Procedures:
-Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart.
-Outdated, contaminated, or deteriorated medications in those in containers that are cracked, soiled or without secure closures are immediately removed from inventory disposed of according to procedures for medication disposal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 6 According to https://ceufast.com/course/long-term-care-nursing-medication-pass Long-Term Care Nursing: Medication Pass was credited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation dated 12/21/21, indicated, ..." More specifically, do NOT, under any circumstances, try to pre-pour medications to save time. Pre-pouring medications are against regulations. In addition, it increases the risk of making mistakes".	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine shaving for 3 of 3 residents (R15, R79, R18) reviewed for activities of daily living (ADL) who were dependent on staff for cares. In addition the facility failed to provide nail care for 1 of 3 residents (R18) who were dependent on staff for cares. Findings include: R79's face sheet printed 3/10/22, indicated R79 was admitted on 2/27/22 with diagnoses including chronic pain, delirium (a mental state characterized by confusion, anxiety), Bell's palsy (a condition causing paralysis on one side of the	F 677	SPECIFIC RESIDENTS: Resident R15 and R18 affected by the alleged deficient practice remain within the facility. Resident R79 had discharged from the facility. Residents R14 and R18 have had their fingernails and facial hair trimmed per individual preference. Residents care plans have been updated on resident preferences and schedules for ADL's. OTHER RESIDENTS: All residents in the facility will have their facial hair and fingernails reviewed for preferences and completed if needed. All residents care plans will be updated to reflect resident's	4/4/22

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F 677	Continued From page 7 face) and severe sepsis with septic shock (life threatening condition from the body's response to infection). R79 's admission Minimum Data Set (MDS) assessment dated 2/23/22 indicated severe cognitive impairment, no care refusal behaviors, and required extensive assist of one to two for personal hygiene. R79's care plan dated 2/22/22, indicated R79 was limited in ability to maintain grooming/personal hygiene related to weakness. The plan of care included setting up resident with electric shaver and cue him to shave self. Provide assistance for facial hair removal as needed. On 3/7/22, at 6:11 p.m. R79 was observed seated in a wheelchair with whiskers present on lower face and neck approximately 1/3 inches in length. During interview a family member (FM)-E indicated the resident hasn't been shaved over the past 3 days and the last time he was shaved, she brought his razor from home and shaved him herself. R79 indicated he would like to be shaved at least every other day. On 3/8/22, at 2:43 p.m., R79 was lying in bed with no whiskers present. During interview, R79's FM-E indicated they didn't offer to shave him so she shaved him today. FM-E added no one has offered to shave him since he has been here for 20 days and this is the second time she has shaved him. FM-E stated she brought his razor from home both times and will take it home again so it doesn't get lost. FM-E added they have razors here so so doesn't know why they don't shave him.	F 677	individual preferences and daily/weekly schedule for completion of tasks. Resident's preferences will be reviewed quarterly per the MDS schedule for preference changes and to assure proper supply for completion of facial hair and nails. Director of Nursing or designee will provide education on resident preferences and care plan will be completed for all licensed associates by April 4, 2022. MONITOR: The Director of Nursing or Designee will audit the completion of resident preferences relating to facial hair and fingernails for eight residents for four weeks. Then audit four residents weekly for an additional two weeks. Results will be provided to Quality Council.	

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F 677	Continued From page 8 During observation and interview on 3/9/22, 7:19 a.m., R79 was in dining room in his wheelchair with whiskers present on lower face and neck approximately, 1/8" in length. R79 indicated staff washed him up this morning and changed his clothes, but did not offer to assist him with shaving. During interview on 3/9/22, at 7:48 a.m., nursing assistant (NA)-B indicated she was unsure if they have any razors at the facility and asked registered nurse (RN)-C. NA-B indicated residents should be shaved daily. During interview on 3/9/22 at 7:50 a.m., RN-C indicated the facility asks family members to bring in a razor as the facility does not provide an electric razor. RN-C indicated they do have some small disposable razors with blades, but has never witnessed staff use them. RN-C added that R79 had scabs on his face when he first came to the facility, but have been healed for about the last week and R79 should be shaved daily. On 3/10/22, at 9:05 a.m., R79 was observed in the dining room with two days of whiskers present. During interview on 3/10/22, at 9:07 a.m., NA-C indicated families are supposed to bring razors in for residents and they are educated on this when the resident is admitted to the facility. NA-C stated they used to have a razor, but is unsure what happened to it, and are not allowed to use any blade type of a razor. NA-C indicated she was not aware R79's family member was shaving him.	F 677		

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During interview on 3/10/22, at 9:45 a.m., RN-B indicated the unit does not have an electric razor and the facility only provides a tooth brush, tooth paste and a few other items. RN-B indicated on admission, they will ask the family member to bring one from home. RN-B indicated FM-E brought one in a few days ago and took it upon herself to shave R79. RN-B indicated yesterday a request was made for the FM-E to bring R79's razor from home and leave it at the facility and added R79 was told if he doesn't get shaved, RN-B will shave him. RN-B indicated R79 had scabs and lesions on his face initially but they are now healed.

On 3/10/22, 1:43 p.m. an interview with the director of nursing (DON) indicated when residents are admitted from the hospital, the hospital provides a list of items for the family to bring to the skilled nursing facility, which includes an electric razor. The DON did confirm residents should be shaved daily and it is a standard of care.

R18

R18's facesheet printed on 3/10/22, indicated diagnoses of dementia and Alzheimer's disease.

R18's quarterly Minimum Data Set (MDS) assessment dated 12/15/21, indicated R18 had severe cognitive impairment and required extensive assistance of one staff for personal hygiene.

R18's plan of care initially reviewed upon entrance indicated R18 needed assistance of one staff to perform grooming/personal hygiene as a result of dementia. In addition, R18 was to receive a bath/shower in which staff were to provide nail care to hands. This care plan focus

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area was started on 9/17/20 and did not specify measures to manage chin hair.

During an observation on 3/7/22, 2:59 p.m., R18 was sitting in a wheelchair in her room. Observed approximately six long chin and right cheek hairs, one quarter inch to approximately two inches in length, gray or white in color. Also observed long, manicured fingernails with dark material underneath the nails. Nails had been polished, but some polish was missing from each finger. Dark reddish material was noted to have dripped down and dried on the outer aspect of R18's little finger, right hand.

During a telephone interview on 3/7/22, at 7:11 p.m., family member (FM)-C stated she was aware of R18's chin and cheek hairs, and stated she noticed them the last time she was there, adding "Mom wouldn't have liked that."

During an observation on 3/8/22, at 1:38 p.m., R18 was lying in bed sleeping. Chin and cheek hairs still present.

During an interview on 3/8/22, at 1:56 p.m., nursing assistant (NA)-D was asked about documentation of resident baths and provided a binder with completed bath sheets. For R18, there were two bath sheets dated 2/2, and 2/23/22. There was a spot to document "nail care completed -- yes or no." This was blank on both sheets. There was no spot to document if chin hair was addressed. NA-D was not able to say if R18 had a bath since 2/23/22, as bath sheets were not always placed in the binder. When asked about shaving female residents, NA-D stated staff shaved chin hairs when they saw them and families were to provide an electric

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razor for this purpose.

During an interview and observation on 3/8/22, at 2:08 p.m., together with NA-D, went to R18's room where R18 was resting in bed. NA-D confirmed the long chin and cheek hairs, stating that should have been taken care of on bath day. NA-D looked in the dresser next to bed and in the bathroom for an electric razor but there was none. NA-D looked at R18's fingernails and acknowledged dark material under the nails and peeling nail polish. NA-D stated that chin hair and nail care should both be done on bath day, or whenever staff noticed it.

During an interview and observation on 3/8/22, 2:44 p.m., together with licensed practical nurse (LPN)-F, went to R18's room where R18 was resting in bed. LPN-F looked at R18's nails and chin hair. LPN-F picked up both hands and looked at front and backs of nails, stating "they need to be cleaned...it's probably food." LPN-A acknowledged R18's chin hairs and stated they were usually taken care of on bath day or whenever it was noticed by staff outside of bath day. LPN-F looked in the bathroom for an electric razor, but couldn't find one, adding that family needed to provide it.

During an interview on 3/8/22, at 2:53 p.m., registered nurse (RN)-A stated nail care was done with every bath; that was the minimum expectation, and also anytime staff noticed they were dirty. RN-A looked at bath sheets for R18 acknowledged there was nothing documented for R18's nail care for baths on 2/2, and 2/23/22. RN-A stated R18's family member preferred they plucked R18's chin hairs, adding that any staff could notice they need to be plucked..."It's a

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dignity issue; anyone, any shift, can notice and report this. I've plucked them myself." RN-A verified that managing R18's chin hair was not identified in her plan of care.

R18's plan of care edited on 3/9/22, by registered nurse (RN)-A indicated R18 had facial whiskers and wanted staff to pluck them with a tweezer when they were long.

During an interview on 3/10/22, at 9:25 p.m., the director of nursing (DON) stated she expected that on bath day, that chin hair and fingernails were looked at and cleaned, adding that R18 tended to eat with her fingers..."We expect staff clean her hands after eating." The DON confirmed that all staff were responsible for identifying chin hair and dirty fingernails and speaking to the staff who can address it.

R15

R15's face sheet printed 3/10/22, indicated R15 was admitted on 6/2015, and diagnoses indicated depression, dementia, muscle weakness, and deformity of left finger.

R15's quarterly Minimum Data Set (MDS) assessment dated 12/8/21, indicated severe cognitive impairment, no care refusal behaviors, required extensive assist personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands.

R15's care plan dated 3/7/22, indicated R15 was limited in ability to maintain grooming/personal hygiene related to abnormality of gait, restless leg syndrome, muscle weakness, and intellectual disabilities, the care plan did not indicate interventions related to facial hair.

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F 677	Continued From page 13 On 3/7/22, at 2:28 p.m. R15 was observed seated in a wheelchair and skin area above upper lip with varied lengths (approximately 1/2 inch) black and brown whiskers and hairs. On 3/9/22, at 8:20 a.m. R15 was observed in the dining room seated in wheelchair well groomed, clean clothes, with varied lengths of black whiskers and hair above upper lip. On 3/9/22, at 8:26 a.m. an interview with nursing assistant (NA)-A indicated she assisted R15 with morning ADL cares this morning, and indicated R5 was dependent on staff for hygiene cares and shaving. NA-A stated R15 was expected to be shaved during morning cares, indicated R15 hairs above her upper lip were long and needed shaving, and further confirmed staff or herself had not completed the task for R15. Review of R15's progress notes identified there was no mention of any refusal of care. On 3/9/22, 1:43 p.m. an interview with the director of nursing (DON) confirmed she would expect residents to be shaved during cares or anytime a resident is identified with facial hair and indicated shaving was a standard of care. Facility policy titled Activities of Daily Living (ADL), dated 2021, indicated residents would be provided with care, treatment and services to maintain or improve their ability to carry out ADL's. Residents unable to carry out ADL's independently would receive services necessary to maintain grooming and personal hygiene, including bathing, dressing, grooming and oral care.	F 677		

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F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess resident's skin to prevent facility acquired pressure ulcers and provide consistent skin monitoring for 1 of 3 residents (R28) reviewed for pressure ulcers. This caused actual harm for R28 who developed a stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough [non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed] may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.). Findings include: R28's face sheet printed 3/9/22, indicated R28 was admitted to the facility 5/15, and diagnoses	F 686	SPECIFIC RESIDENTS: Resident R28 affected by the alleged deficient practice remains in the facility. Resident R28 has had a Skin Risk Assessment with Braden Scale assessment completed. Resident has had pressure ulcers measured and this will continue weekly. Residents care plan has been reviewed, updated, and implemented for prevention or worsening of pressure ulcers. OTHER RESIDENTS: All long term residents will have a Skin Risk Assessment with Braden Score completed. Residents with pressure ulcers will have treatments, interventions and weekly skin monitoring. Comprehensive care plans will be reviewed, updated and implemented for prevention or worsening of pressure ulcers. Residents will have quarterly	4/4/22

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F 686	Continued From page 15 included diabetes, heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body ' s needs for blood and oxygen), lymphedema (build-up of fluid in soft body tissues), dementia, dermatitis (skin irritation), venous insufficiency (leg veins constrict blood to flow back to the heart), edema (swelling). R28's quarterly Minimum Data Set (MDS) assessment dated 1/12/22, identified R28 had moderately impaired cognition, no rejection of care, required extensive assist with bed mobility and transfers, limited assist with dressing, utilized a walker and wheelchair. Further, the MDS identified R28 was at risk for developing pressure ulcers/injuries, had two venous (type of chronic wound due to damage of skin tissue from lack of proper circulation of the blood back to the heart or stagnation of the blood) and atrial (type of chronic wound due to the damage to skin tissue from a lack of blood flow to the tissues from the heart) ulcers present, required a pressure relieving device for the chair and bed, application of non-surgical dressings, application of ointments/medications, and application of dressings to feet. R28's Care Plan printed 3/8/21, identified R28 had impaired skin r/t (related to) venous insufficiency to bilateral lower extremities; interventions included monitor for s/s (signs/symptoms) if infection noted notify MD/NP (medical doctor/nurse practitioner), observe for s/s (signs/symptoms) of pain, wraps bilateral to LE (lower extremity) as ordered, conduct a systematic skin inspection during weekly with bath, daily checks with daily am/pm cares, pay particular attention to the bony prominence, and	F 686	following the MDS schedule Braden Scale for Prediction of Pressure Sore completed for ongoing assessment. Director of Nursing or designee will provide nursing associates education on pressure ulcer monitoring and importance of following care plan for impaired skin integrity by April 4, 2022. MONITOR: The Director of Nursing or Designee will audit four residents for the first four weeks to assure care plan is followed for implementation of interventions for prevention or prevention of worsening of pressure sores is completed. Director of Nursing or designee will audit that if the resident is within their MDS window that the Braden Score for Prediction of Pressure Sore assessment is completed. Then will audit two residents weekly for an addition two weeks. Results will be provided to Quality Council for reassessment.	

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report concerns to nursing. for prompt treatment, provide staff assist of 1 for guiding legs into bed. Resident can assist with repositioning.

R28's care plan lacked identification of R28's stage 3 pressure ulcer to left heel and lacked any further interventions related to the care of R28's pressure ulcer to minimize the risk of additional pressure ulcer development, including floating heels, refusal of care, following dressing change orders per wound nurse or as ordered, monitoring for healing, signs of infection.

R28's Medication Administration Record (MAR) dated 2/8/22, through 3/9/22, indicated start date 11/15/19, ace wrap toes to knee on every AM, off every HS [bedtime] to decrease swelling. Order started on 2/8/22, indicated clean left heel with NS [normal saline], apply Bacitracin (antibiotic ointment), apply Mepilex (absorbent foam dressing) once daily.

R28's Event Report: Skin Integrity Event's Pressure Sore/Statis Ulcer dated 2/8/22, completed by licensed practical nurse (LPN)-A, wound nurse identified pressure ulcer treatment and measuring of stage 3 pressure ulcer was completed. The form had a section to include interventions, skin treatments applied during last 7 days, measures taken, however section on form incomplete. The form further indicated treatments dated 2/8/22, float heels while in bed. LPN-A note on the form indicated, writer was completing resident AM treatment. When writer was wrapping resident's legs, resident c/o [complained of] of her left heel being sore. Writer observed resident heel and noted an open area on the back of her heel. Area was measured 1 cm x 0.8 cm x 0.3 surrounding tissue intact.

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F 686	Continued From page 17 R28's Skin Condition documentation from 2/8/22-3/9/22, included the following: On 2/8/22, a new pressure ulcer was identified on R28's left heel as a stage 3 pressure ulcer and measured 1 cm x 0.8 cm x 0.3 cm.. The pressure ulcer was described as left heel being pain sore, open area on the back of her heel, surrounding tissue is intact. On 2/9/22, at 3:19 p.m. wound treatment completed with measurements. Left heel wound 1 cm x 0.8 cm x 0.3 cm. Both calves surrounding tissue dry scaly irritated skin. On 2/9/22, at 12:36 a.m. left heel painful but ok when floated on pillow. Continue to monitor. On 2/16/22, at 3:18 p.m. wound tx [treatment] completed with measurements. Left heel wound 0.6 cm x 0.8 cm x 0.2 cm. On 2/16/22, at 4:51 a.m. refused to float heel with pillow. She (R28) states it hurts more with pillow. Has legs elevated with bed controls. Continue to monitor heels. On 3/3/22, 2:53 p.m. wound treatment complete.. Left heel wound 0.8 cm x 0.6 cm x 0.3 cm. On 3/9/22, 12:59 p.m. left heel measures 0.8 cm x 0.9 cm x 0.2 cm. Wound bed 100% granulation. No drainage. No odor. Wound edge calloused. Peri-wound intact without redness. Resident denied pain at time of writers assessment. R28's medical record lacked a comprehensive assessment: to include the potential	F 686		

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causative/contributing factors when the pressure ulcer developed, and education to staff to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing and reoccurrence.

On 3/8/22, at 1:46 p.m. R28 was in her room seated in her wheelchair, and indicated her legs were wrapped with ACE wraps, R28 was observed and used her feet to self propel in the wheelchair from her room to the dining area, approximately 30 feet.

On 3/9/22, at 12:37 p.m. observed R28 in her room seated in wheelchair with medical doctor (MD) and LPN-C. LPN-C stated resident had COVID in early January and indicated R28 may had been weaker during that time. LPN-C indicated staff were expected to assist R28 with reposition and assist resident in bed, MD-A stated today was the first time she visually accessed the left heel pressure ulcer, and described the area as round shallow, dry, and clean. MD-A stated the left heel open area would be related to pressure. MD-A stated staff had notified her of the ulcer and orders were given. MD-A stated staff were expected to visually monitor bony prominence and including heels daily.

On 3/9/22, at 1:14 p.m. LPN-C stated she had completed a course in wound certification. LPN-C indicated she was notified by LPN-A on 2/8/22, of an open and painful area on R28's left heel. LPN-C further indicated she assessed R28's left heel 2/8/22, and the left heel was staged at a stage three pressure ulcer due to full thickness loss. LPN-C indicated R28's interventions prior to the resident identified pressure ulcer were weekly body audit, staff assist of one to guide into

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bed and resident can assist with repositioning, daily checks of bony prominence, and was expected for nursing assistants or nurse to report for prompt treatment. LPN-C sated R28 was dependent of staff to put her socks on daily. LPN-C indicated and IDT [interdisciplinary team] was completed 2/11/22, and indicated comorbidities of R28 included diet, cognition and added interventions interventions daily treatment until area is healed, encourage resident to elevate legs and to use right foot for locomotion to and from room and lounge. LPN-C stated the new interventions were expected to be included on the care plan and confirmed the interventions were not on the care plan prior to 3/9/22. LPN-C further indicated NA's and nursing staff would be aware of the interventions through the care plan. LPN-C indicated the left heel pressure ulcer was still identified as a healing stage three.

On 3/9/22, 1:37 p.m. the director of nursing (DON) stated the expected staff to identify a pressure ulcer prior to a stage three and expected residents at risk including R28 to have intervention that included pressure reliving mattress, skin inspections, float heels.

On 3/9/22, at 3:44 p.m. an interview with the DON and LPN-C indicated the facility had not completed audits on residents with risk of skin breakdown or pressure sores and had not provided staff education on comprehensive skin assessment that included heels to ensure other like residents were assessed comprehensively

On 3/10/22, at 9:17 a.m. during a phone interview with MD-A indicated she expected staff would have identified R28's heel sore prior to a stage three pressure ulcer and expected causative

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factors and interventions to prevent future skin concerns for R28, and confirmed the stage three pressure ulcer with the comprehensive visual assessment and interventions could have been prevented.

On 3/10/22, at 10:21 a.m. LPN-A, stated she completed weekly body audits on R28 and confirmed R28's wound on right calf, lower left leg, and pressure ulcer on the left heel left heel which showed up within the last month. LPN-A indicated R28 self propelled in her wheelchair, and was not in bed that much except for at night when R28 slept. LPN-A confirmed she identified the pressure ulcer on R28's left heel on 2/8/22. LPN-A indicated for the week prior to 2/8/22, R28 complained of left heel pain daily and LPN applied lotion to her heel and felt the residents heel, but confirmed she failed to visually assess R28's heel. LPN-A stated if R28's heel was visually inspected prior to 2/8/22, and possible interventions would have been implemented, R28's possible could have been prevented the left heel to develop to a stage 3 pressures ulcer. LPN-A indicated assessment of bony prominence would include the heels LPN-A stated the facility had not provided any additional education related to comprehensive skin assessments after the incident, and further stated the incident, "opened my eyes to look at heels"

Policy titled Prevention and Treatment of Skin Breakdown dated 2018, indicated
Purpose: maintaining intact skin is integral to resident health and wellness. Care and service are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur.
Procedure:

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F 686	Continued From page 21 1. Skin Assessment: A resident centered care plan is implemented updated for skin risk with interventions based upon area of risk, resident assessment, Braden new valuation score 15 or less clinicians assessments less evaluation, resident preferences 2. Members of the care team are notified and consulted as necessary 3. Skin integrity is monitored and abnormal findings are documented, skin is observed daily with cares, if any skin concerns are noted there reported to the licensed nurse, weekly skin audits are performed by a licensed nurse. 4. A therapy evaluation is requested as appropriate 5. Education is provided the resident and resident representative as indicated Treatment of impaired pressure injury and lower extremity ulcers: 1. notify supervisors/designee, 2. evaluate current pressure reduction interventions and revise resident centered care plan 3. notify dietitian for nutritional intervention 4. Notify therapy associates and other members of the care team as appropriate for possible interventions, 5. When pressure injury is present, the dressing or wound is monitored as appropriate 6. Weekly the licensed nurse will stage, measure and examine the wound bed and surrounding skin. If the wound bed has deteriorated notify provider. 7. Documentation reflex areas as addressed above Definitions : Stage three pressure injury full thickness skin	F 686		

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F 686	Continued From page 22 loss full thickness loss skin, in which adipose is visible and ulcer in granulation tissue enrolled wound engines are often present. Sloth or eschar may be visible the depth of tissue damage varies by location	F 686		
F 806 SS=B	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that individual food preferences/food choices were assessed for 5 of 5 residents (59, R232, R53, R37 and R56) reviewed for food preferences. Findings include: R59's quarterly BIMS (brief interview for mental status) assessment on 2/9/22, indicated mild cognitive impairment. R59 was admitted in 2021. During an interview on 3/7/22, at 3:16 p.m., when asked about meals and food, R59's family member (FM)-G stated, "Supper meals are skimpy", and R59 would like bigger portions. In addition, FM-G stated R59 doesn't like fish and received fish last week. FM stated no one had	F 806	F806 Resident Allergies, Preferences, Substitutes SPECIFIC RESIDENTS: Residents R232, R37, R56 and R59 affected by the alleged deficient practice remain in the facility. Resident R53 affected by the alleged deficient has discharged. Resident's meal preferences have been reviewed by the culinary director. All residents preferences on meals have been updated in Mealsuite and their care plan. OTHER RESIDENTS: All residents within the facility will have meal preferences reviewed. All new admissions will meet with the culinary director or designee with in the first seven days to review meal preferences. Resident's preferences will	4/8/22

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F 806	Continued From page 23 asked her or R59 about food preferences, likes and dislikes. R232 R232's admission BIMS assessment dated 3/6/22, indicated R232 was cognitively intact. R232 was admitted within the past 30 days During an interview on 3/7/22, at 4:49 p.m., when asked about meals and food, R232, who ate in her room, stated breakfast and lunch were good, but supper was fair. "I could have a little more individualized food." R232 received a polish sausage on a white hot dog bun for supper and stated she had never had so much processed meat. Observed that the sausage was eaten and the hot dog bun was still on her plate. R232 stated "I don't eat white bread." R232 stated no one had asked her about her food preferences. R232's paper diet slip on her table had no food preferences, likes or dislikes listed on it. There was no documentation in the electronic medical record (EMR) of an interview by culinary staff regarding food preferences, likes and dislikes. R53 R53's admission BIMS assessment dated 2/13/22, indicated R53 was cognitively intact. R53 was admitted on 2/7/22. During an interview on 3/7/22, at 4:05 p.m., when asked about meals and food, R53, who ate in her room, stated food did not taste good; always canned fruit, no flavor and meat was dry. During an interview on 3/7/22, at 5:50 p.m., R53 had eaten a polish sausage, but not the bun, stating, "Too much bread here." Had canned pears for dessert, stating "Too much canned fruit. I'm used to eating fresh fruit." R53 stated no one had	F 806	be documented in Mealsuite and their individual care plan. Quarterly per MDS schedule residents will be interviewed to review their meal preferences and are served at meals. Residents will, in addition, be interviewed for satisfaction and any changes the resident requests per interview. Their care plan and meal suit will be reviewed and updated. Director of Culinary Services will provide education to all associates on the procedure for culinary assessment and documentation on meal preferences and care planning by April 4, 2022. MONITOR: The Director of Culinary or Designee will audit four residents for the first four weeks to assure culinary assessment and meal preferences completed and assure preferences are being delivered at desired meals and/or times. Then will audit two residents weekly for an additional two weeks. Results will be provided to Quality Council for reassessment.	

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F 806	Continued From page 24 asked her about food preferences, such as likes and dislikes. R53's diet card indicated an allergy to fish, but did not indicate food preferences, likes or dislikes. There was no documentation in the EMR of an interview by culinary staff regarding food preferences, likes and dislikes. R37 R37's quarterly BIMS assessment dated 1/26/22, indicated R37 was cognitively intact. R37 was admitted in 2020 R56 R56's quarterly BIMS assessment dated 2/9/22, indicated R56 was cognitively intact. R56 was admitted in 2020. During resident council meeting interview on 3/8/22, at 3:56 p.m., R37 and R46 were in attendance. When asked if staff talked to them about food preferences, likes, dislikes and portion sizes, R37 stated "no one has ever asked me likes and dislikes." R56 stated "we haven't had the opportunity to do that at all." During an interview on 3/9/22, at 9:38 a.m., culinary services supervisor (CSS)-A stated someone from culinary services met with new admissions, adding they had a likes and dislike chart and they brought it along to ask residents what types of meals they liked. CSS-A stated the culinary services director (CSD)-B met with residents right away unless he delegated it to CSS-A. CSS-A was asked for documentation that R53, R59 and R232 were asked about food preferences, likes and dislikes, and also copies of various menu's that were observed during the kitchen tour.	F 806		

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F 806	Continued From page 25 On 3/9/22, at 4:06 p.m., CSS-A and the administrator provided copies of various menu's as requested, but not documentation that R53, R59 and R232 were asked about food preferences, likes and dislikes. During an interview on 3/10/22, at 9:05 a.m., the administrator was informed that despite requesting both verbally and in writing, documentation that R53, R59 and R232 were asked about food preferences, it had not been received. During an interview on 3/10/22, at 10:05 a.m., while speaking to registered nurse (RN)-A in a nurses office, CSS-A and the administrator came in and stated culinary staff met with residents, filled out a sheet regarding food preferences, including likes and dislikes and the entered this information into an electronic program called Meal Suite, then discarded the sheet. CSS-A and the administrator were asked to provide documentation of this by printing the information from Meal Suite that indicated who met with the resident, on what date, and what food preferences, likes and dislikes were documented. CSS-A and the administrator were asked to select five recent admissions to demonstrate that this was being done. RN-A overhead the conversation and provided a form that appeared to have been copied many times. The form was crooked and the heading was cut off. The word "date" followed by a line were partially visible at the top. RN-A stated the facility used to use this form. The form had three columns indicating different types of food: dairy, meat, fish, soups, beverages, vegetables/starches and cereal. After each of the food columns were two blank columns with headings of likes and dislikes. In addition, there	F 806		

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were spots to write in notes about portion size, food allergies and intolerance's, cultural/ethnic/religious food requests. At the bottom of the form it indicated to fill out and return to "CDM" (certified dietary manager). CSS-A and the administrator looked at the form, but indicated they were not aware of it.

During an interview on 3/10/22, at 11:16 a.m., CSS-A was again asked if residents were being interviewed by culinary staff to determine food preferences, likes and dislikes. CSS-A stated neither he nor CSD-B had been doing this. CSS-A acknowledged the culinary staff should know resident food preferences, likes and dislikes in order to provide a positive meal experience, adding "I think we should be doing it - food is important to residents."

During an interview on 3/10/22, at 1:55 p.m., the administrator provided additional documents showing evidence that food, in general, was discussed at quarterly care conferences, however, the administrator was not able to say if culinary staff meet with residents individually to ascertain their food preferences, likes and dislikes.

During an interview on 3/10/22, at 3:48 p.m., the administrator stated she believed residents were asked about food preferences at quarterly care conferences which were lead by social services, and which culinary staff did not attend. The administrator stated care conferences for newly admitted residents occurred within about five days of admission and if a resident brought up a significant food concern, then an in-depth interview would occur with culinary services. The administrator was informed the facility policy

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F 806	Continued From page 27 titled: Initial Visit/Diet History for Community Admissions, dated 2012, indicated the culinary service director/dietician/designee would visit all residents upon admission and document the summary of the visit and the outcome in the residents medical record. Information would include a request for food and beverage preferences and dislikes; special needs, concerns or questions that needed to be addressed. The administrator stated the former culinary services director used to meet with new residents, but was unaware if CSD-B continued the practice. The administrator stated she would look into this. Facility policy titled Initial Visit/Diet History for Community Admissions, dated 2012, indicated the culinary service director/dietician/designee would visit all residents upon admission and document the summary of the visit and the outcome in the residents medical record. Information provided would include: a welcome to the facility, introduction of culinary services director and department, time of meals and between meal nourishments, request for food and beverage preferences and dislikes, review diet order and special needs, concerns or questions that needed to be addressed. This admission visit was to be documented in the residents medical record.	F 806		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		4/4/22

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F 880	Continued From page 28 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 29 (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an unvaccinated resident socially distanced during congregate dining for 1 of 1 unvaccinated resident (R54) residing on the Kindle neighborhood. This had the potential to affect all 5 residents who sat at the same table with R54 during dining. Findings include: R54's Resident Face Sheet printed 3/10/22, indicated R54 was admitted 2/8/22, and diagnoses including COVID-19 and type II diabetes. R54's care plan printed 3/10/22, directed to	F 880	SPECIFIC RESIDENTS: Resident R54 affected by the alleged deficient practice has discharged from the facility. Immediate education was provided to licensed associate on procedure for social distancing of residents that are not fully vaccinated. All residents in the facility were monitored for signs and symptoms of illness relating to resident R54. No residents in the facility have had signs or symptoms of Covid-19. OTHER RESIDENTS: All current short term residents will be reviewed for full compliance of Covid-19 Vaccination status and all new admissions are screened upon admission. If a resident is	

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F 880	Continued From page 30 educate staff, resident, family and visitors of COVID-19 signs and symptoms and precautions. The care plan further directed to follow facility protocol for COVID-19 screening/precautions. R54's Covid 19 Vaccine Consent form, signed/dated 2/8/22, indicated R54's representative declined the Covid 19 vaccine for R54 and understands the risk, benefits and consequence of declination. The care plan did not identify an intervention of social distancing. On 3/9/22, at 12:00 p.m. R54 was observed seated in the Kindle neighborhood dining room at a rectangular table approximately 4 x 6 feet in diameter. R54 was seated centrally on the 6 foot side of the table with five other residents (R43 ,R53, R63, R74, R77) seated around the table with him; all residents were without a mask and were eating their lunch meal. R54 was not socially distanced 6 feet or greater, from the other five residents. Staff were not observed to offer or coach R54 to socially distance six feet or greater as recommended by the CDC. On 3/10/22, at 11:52 a.m. R54 was observed seated in the Kindle neighborhood dining room at the same rectangular table with three other residents (R53, R63, R74); all were unmasked and eating their lunch meal. R54 was not socially distanced 6 feet or greater from the other three residents nor did staff offer or coach R54 to socially distance six feet or greater. On 3/10/22, at 11:56 a.m. licensed practical nurse (LPN)-E stated being unaware of any residents in the Kindle neighborhood who were not vaccinated. LPN-E confirmed upon admission	F 880	not fully up to date with Covid-19 vaccination an educational sign will be placed on his/her medication cabinet where their face mask is located. The educational sign will state the guidelines for a resident that is not fully vaccinated. This will include but limited to the resident must wear a mask at all times when in the presence of another peer and if unable must, maintain social distance of 6 feet at all times. This includes that the resident is unable to dine with peers at the same table and is recommend to enjoy all meals in his/her bedroom. If the resident must dine in the dining room they must eat at a separate table and maintain social distance of 6 feet at all times. This sign will also be an additional alert for staff on resident□s vaccination status along with the information on their face sheet. Director of Nursing will provide education to all associates on the procedure for Infection and Prevention relating to resident Covid-19 vaccination status by April 4, 2022. MONITOR: The Director of Nursing or Designee will audit 6 residents on vaccination status and following MDH guidelines on mask usage and social distancing weekly for the first four weeks. Then audit three residents twice weekly for an additional two weeks. Results will be provided to Quality Council for reassessment. Documents Uploaded for support of F880 corrections are 1.RCA 2.Resient Immediate Audits 3.Education provided	

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 _____	C 03/10/2022

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

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F 880	Continued From page 31 unvaccinated residents were quarantined to their room and on droplet precautions for 14 days following admission. When their 14 days were up, unvaccinated residents were expected to wear a mask and social distance when leaving their room. On 3/10/22, at 1:40 p.m. LPN-C/infection preventionist (IP), confirmed she had not provided any guidance to unvaccinated residents other than encouraging them to wear a mask when leaving their own neighborhood. LPN-C/IP confirmed the current CDC guidance and facility policy indicated unvaccinated residents were to socially distance six feet or greater. On 3/10/22, at 3:52 p.m. director of nursing (DON) confirmed R54 should have been social distancing in the dining room when eating meals. The policy titled, Benedictine Visitor Guidance Summary, updated 12/30/21, indicated: Residents who are unable to wear a mask due to a disability may attend communal activities if they are able to social distance. If possible educate the resident on the core principles of infection prevention. Staff should provide frequent reminders to adhere to infection prevention principles. The Center for Disease Control (CDC) "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" updated 2/2/22, recommended source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for	F 880	for staff 4.Staff sign in sheets for education 5.ongoing daily/shift audits	

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F 880	Continued From page 32 individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission or who have: Are not up to date with all recommended COVID-19 vaccine doses.	F 880		

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 _____	**03/09/2022**

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 An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/09/2022. 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		03/29/2022

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 _____	**03/09/2022**

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

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K 000	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 one-story building with no basement and is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The original building was constructed in 2013 and was determined to be of type V (111) construction. The facility has a capacity of 79 beds and had a census of 77 at the time of the survey.	K 000		

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 _____	**03/09/2022**

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

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K 000	Continued From page 2	K 000		
K 291 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the emergency lighting system per NFPA 101 (2012 edition), 19.2.9.1 and 7.9.3.1.1 (3,4,5). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/09/2022 between 10:30 AM to 12:30 PM, a review of the available documentation revealed that documentation could not be provided to show that an annual 90-minute test of the emergency lighting had occurred. An interview with the Facility Administrator verified this finding at the time of discovery.	K 291	Facility emergency lighting system will be tested for 90 minutes on a yearly basis. This test was completed on March 16, 2022 by facility Maintenance Department associates. All Maintenance associates were educated on this task. A new annual system check was put into place with TELS, our facility environmental management system. Environmental Director and Maintenance Department associates complete facility maintenance tasks and processes as indicated by our TELS management system. Executive Director has reviewed TELS system to ensure a new emergency light test system check has been set up and will review TELS logs for 3 months to ensure compliance with correct response to management system. The 90-minute test, associate education and a new TELS tasks list were completed by March 16, 2022.	4/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect fire door assemblies per NFPA 101 (2012 edition), Life Safety Code, section 19.7.6 and 8.3.3.1 and NFPA 80 (2010 edition), Standard for Fire Doors, and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/09/2022 between 10:30 AM to 12:30 PM, during a review of the available documentation, it was revealed that documentation could not be provided to show that an annual fire door inspection and testing had occurred. An interview with the Maintenance Director verified this finding at the time of discovery.	K 761	Facility fire door tests and inspections on all fire doors will be completed annually. These testing and inspections were completed on March 24, 2022 by facility Maintenance department associates. All Maintenance associates were educated on these tasks. A new annual system check was put into place with TELS, our facility environmental management system. Environmental Director and Maintenance Department associates complete facility maintenance tasks and processes as indicated by our TELS management system. Executive Director has reviewed TELS system to ensure a new fire door annual test and inspection process has been set up and will review TELS logs for 3 months	4/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 761	Continued From page 4	K 761	to ensure compliance with correct response to management system. All facility fire doors were tested and inspected and associate education completed on March 24, 2022 and a new TELS tasks list was completed by March 16, 2022.	

Electronically delivered
March 23, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: VC6211

Dear Administrator:

The above facility was surveyed on March 7, 2022 through March 10, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
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
	00644	A. BUILDING: _____ B. WING _____	C 03/10/2022

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/7/22 - 3/10/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5426057C (MN81219) however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5426058C (MN80635). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess resident's skin to prevent facility acquired pressure ulcers and provide consistent skin	2 900	SPECIFIC RESIDENTS: Resident R28 affected by the alleged deficient practice remains in the facility. Resident R28 has had a Skin Risk Assessment with Braden	4/4/22

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2 900	Continued From page 3 monitoring for 1 of 3 residents (R28) reviewed for pressure ulcers. This caused actual harm for R28 who developed a stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough [non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed] may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.). Findings include: R28's face sheet printed 3/9/22, indicated R28 was admitted to the facility 5/15, and diagnoses included diabetes, heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body ' s needs for blood and oxygen), lymphedema (build-up of fluid in soft body tissues), dementia, dermatitis (skin irritation), venous insufficiency (leg veins constrict blood to flow back to the heart), edema (swelling). R28's quarterly Minimum Data Set (MDS) assessment dated 1/12/22, identified R28 had moderately impaired cognition, no rejection of care, required extensive assist with bed mobility and transfers, limited assist with dressing, utilized a walker and wheelchair. Further, the MDS identified R28 was at risk for developing pressure ulcers/injuries, had two venous (type of chronic wound due to damage of skin tissue from lack of proper circulation of the blood back to the heart or stagnation of the blood) and atrial (type of chronic wound due to the damage to skin tissue from a lack of blood flow to the tissues from the heart) ulcers present, required a pressure relieving	2 900	Scale assessment completed. Resident has had pressure ulcers measured and this will continue weekly. Residents care plan has been reviewed, updated, and implemented for prevention or worsening of pressure ulcers. OTHER RESIDENTS: All long term residents will have a Skin Risk Assessment with Braden Score completed. Residents with pressure ulcers will have treatments, interventions and weekly skin monitoring. Comprehensive care plans will be reviewed, updated and implemented for prevention or worsening of pressure ulcers. Residents will have quarterly following the MDS schedule Braden Scale for Prediction of Pressure Sore completed for ongoing assessment. Director of Nursing or designee will provide nursing associates education on pressure ulcer monitoring and importance of following care plan for impaired skin integrity by April 4, 2022. MONITOR: The Director of Nursing or Designee will audit four residents for the first four weeks to assure care plan is followed for implementation of interventions for prevention or prevention of worsening of pressure sores is completed. Director of Nursing or designee will audit that if the resident is within their MDS window that the Braden Score for Prediction of Pressure Sore assessment is completed. Then will audit two residents weekly for an addition two weeks. Results will be provided to Quality Council for reassessment.	

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2 900	Continued From page 4 device for the chair and bed, application of non-surgical dressings, application of ointments/medications, and application of dressings to feet. R28's Care Plan printed 3/8/21, identified R28 had impaired skin r/t (related to) venous insufficiency to bilateral lower extremities; interventions included monitor for s/s (signs/symptoms) if infection noted notify MD/NP (medical doctor/nurse practitioner), observe for s/s (signs/symptoms) of pain, wraps bilateral to LE (lower extremity) as ordered, conduct a systematic skin inspection during weekly with bath, daily checks with daily am/pm cares, pay particular attention to the bony prominence, and report concerns to nursing. for prompt treatment, provide staff assist of 1 for guiding legs into bed. Resident can assist with repositioning. R28's care plan lacked identification of R28's stage 3 pressure ulcer to left heel and lacked any further interventions related to the care of R28's pressure ulcer to minimize the risk of additional pressure ulcer development, including floating heels, refusal of care, following dressing change orders per wound nurse or as ordered, monitoring for healing, signs of infection. R28's Medication Administration Record (MAR) dated 2/8/22, through 3/9/22, indicated start date 11/15/19, ace wrap toes to knee on every AM, off every HS [bedtime] to decrease swelling. Order started on 2/8/22, indicated clean left heel with NS [normal saline], apply Bacitracin (antibiotic ointment), apply Mepilex (absorbent foam dressing) once daily. R28's Event Report: Skin Integrity Event's Pressure Sore/Statis Ulcer dated 2/8/22,	2 900		

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2 900	Continued From page 5 completed by licensed practical nurse (LPN)-A, wound nurse identified pressure ulcer treatment and measuring of stage 3 pressure ulcer was completed. The form had a section to include interventions, skin treatments applied during last 7 days, measures taken, however section on form incomplete. The form further indicated treatments dated 2/8/22, float heels while in bed. LPN-A note on the form indicated, writer was completing resident AM treatment. When writer was wrapping resident's legs, resident c/o [complained of] of her left heel being sore. Writer observed resident heel and noted an open area on the back of her heel. Area was measured 1 cm x 0.8 cm x 0.3 surrounding tissue intact. R28's Skin Condition documentation from 2/8/22-3/9/22, included the following: On 2/8/22, a new pressure ulcer was identified on R28's left heel as a stage 3 pressure ulcer and measured 1 cm x 0.8 cm x 0.3 cm.. The pressure ulcer was described as left heel being pain sore, open area on the back of her heel, surrounding tissue is intact. On 2/9/22, at 3:19 p.m. wound treatment completed with measurements. Left heel wound 1 cm x 0.8 cm x 0.3 cm. Both calves surrounding tissue dry scaly irritated skin. On 2/9/22, at 12:36 a.m. left heel painful but ok when floated on pillow. Continue to monitor. On 2/16/22, at 3:18 p.m. wound tx [treatment] completed with measurements. Left heel wound 0.6 cm x 0.8 cm x 0.2 cm. On 2/16/22, at 4:51 a.m. refused to float heel with pillow. She (R28) states it hurts more with	2 900		

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2 900	Continued From page 6 pillow. Has legs elevated with bed controls. Continue to monitor heels. On 3/3/22, 2:53 p.m. wound treatment complete.. Left heel wound 0.8 cm x 0.6 cm x 0.3 cm. On 3/9/22, 12:59 p.m. left heel measures 0.8 cm x 0.9 cm x 0.2 cm. Wound bed 100% granulation. No drainage. No odor. Wound edge calloused. Peri-wound intact without redness. Resident denied pain at time of writers assessment. R28's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, and education to staff to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing and reoccurrence. On 3/8/22, at 1:46 p.m. R28 was in her room seated in her wheelchair, and indicated her legs were wrapped with ACE wraps, R28 was observed and used her feet to self propel in the wheelchair from her room to the dining area, approximately 30 feet. On 3/9/22, at 12:37 p.m. observed R28 in her room seated in wheelchair with medical doctor (MD) and LPN-C. LPN-C stated resident had COVID in early January and indicated R28 may had been weaker during that time. LPN-C indicated staff were expected to assist R28 with reposition and assist resident in bed, MD-A stated today was the first time she visually accessed the left heel pressure ulcer, and described the area as round shallow, dry, and clean. MD-A stated the left heel open area would be related to pressure. MD-A stated staff had notified her of the ulcer and orders were given. MD-A stated staff were	2 900		

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2 900	Continued From page 7 expected to visually monitor bony prominence and including heels daily. On 3/9/22, at 1:14 p.m. LPN-C stated she had completed a course in wound certification. LPN-C indicated she was notified by LPN-A on 2/8/22, of an open and painful area on R28's left heel. LPN-C further indicated she assessed R28's left heel 2/8/22, and the left heel was staged at a stage three pressure ulcer due to full thickness loss. LPN-C indicated R28's interventions prior to the resident identified pressure ulcer were weekly body audit, staff assist of one to guide into bed and resident can assist with repositioning, daily checks of bony prominence, and was expected for nursing assistants or nurse to report for prompt treatment. LPN-C sated R28 was dependent of staff to put her socks on daily. LPN-C indicated and IDT [interdisciplinary team] was completed 2/11/22, and indicated comorbidities of R28 included diet, cognition and added interventions interventions daily treatment until area is healed, encourage resident to elevate legs and to use right foot for locomotion to and from room and lounge. LPN-C stated the new interventions were expected to be included on the care plan and confirmed the interventions were not on the care plan prior to 3/9/22. LPN-C further indicated NA's and nursing staff would be aware of the interventions through the care plan. LPN-C indicated the left heel pressure ulcer was still identified as a healing stage three. On 3/9/22, 1:37 p.m. the director of nursing (DON) stated the expected staff to identify a pressure ulcer prior to a stage three and expected residents at risk including R28 to have intervention that included pressure reliving mattress, skin inspections, float heels.	2 900		

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2 900	Continued From page 8 On 3/9/22, at 3:44 p.m. an interview with the DON and LPN-C indicated the facility had not completed audits on residents with risk of skin breakdown or pressure sores and had not provided staff education on comprehensive skin assessment that included heels to ensure other like residents were assessed comprehensively On 3/10/22, at 9:17 a.m. during a phone interview with MD-A indicated she expected staff would have identified R28's heel sore prior to a stage three pressure ulcer and expected causative factors and interventions to prevent future skin concerns for R28, and confirmed the stage three pressure ulcer with the comprehensive visual assessment and interventions could have been prevented. On 3/10/22, at 10:21 a.m. LPN-A, stated she completed weekly body audits on R28 and confirmed R28's wound on right calf, lower left leg, and pressure ulcer on the left heel left heel which showed up within the last month. LPN-A indicated R28 self propelled in her wheelchair, and was not in bed that much except for at night when R28 slept. LPN-A confirmed she identified the pressure ulcer on R28's left heel on 2/8/22. LPN-A indicated for the week prior to 2/8/22, R28 complained of left heel pain daily and LPN applied lotion to her heel and felt the residents heel, but confirmed she failed to visually assess R28's heel. LPN-A stated if R28's heel was visually inspected prior to 2/8/22, and possible interventions would have been implemented, R28's possible could have been prevented the left heel to develop to a stage 3 pressures ulcer. LPN-A indicated assessment of bony prominence would include the heels LPN-A stated the facility had not provided any additional education related to comprehensive skin assessments after the	2 900		

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2 900	Continued From page 9 incident, and further stated the incident, "opened my eyes to look at heels" Policy titled Prevention and Treatment of Skin Breakdown dated 2018, indicated Purpose: maintaining intact skin is integral to resident health and wellness. Care and service are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. Procedure: 1. Skin Assessment: A resident centered care plan is implemented updated for skin risk with interventions based upon area of risk, resident assessment, Braden new valuation score 15 or less clinicians assessments less evaluation, resident preferences 2. Members of the care team are notified and consulted as necessary 3. Skin integrity is monitored and abnormal findings are documented, skin is observed daily with cares, if any skin concerns are noted there reported to the licensed nurse, weekly skin audits are performed by a licensed nurse. 4. A therapy evaluation is requested as appropriate 5. Education is provided the resident and resident representative as indicated Treatment of impaired pressure injury and lower extremity ulcers: 1. notify supervisors/designee, 2. evaluate current pressure reduction interventions and revise resident centered care plan 3. notify dietitian for nutritional intervention 4. Notify therapy associates and other members of the care team as appropriate for possible interventions, 5. When pressure injury is present, the dressing	2 900		

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2 900	Continued From page 10 or wound is monitored as appropriate 6. Weekly the licensed nurse will stage, measure and examine the wound bed and surrounding skin. If the wound bed has deteriorated notify provider. 7. Documentation reflex areas as addressed above Definitions : Stage three pressure injury full thickness skin loss full thickness loss skin, in which adipose is visible and ulcer in granulation tissue enrolled wound engines are often present. Sloth or eschar may be visible the depth of tissue damage varies by location SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable polices and procedures pertaining to the timely assessment and ongoing monitoring of skin; then inservice direct care staff on these policies and the comprehensive assessment of pressure ulcers. The DON, or designee, could then conduct audits to ensure ongoing compliance. The results of those audits could be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary	2 920		4/4/22

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2 920	Continued From page 11 services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine shaving for 3 of 3 residents (R15, R79, R18) reviewed for activities of daily living (ADL) who were dependent on staff for cares. In addition the facility failed to provide nail care for 1 of 3 residents (R18) who were dependent on staff for cares. Findings include: R79's face sheet printed 3/10/22, indicated R79 was admitted on 2/27/22 with diagnoses including chronic pain, delirium (a mental state characterized by confusion, anxiety), Bell's palsy (a condition causing paralysis on one side of the face) and severe sepsis with septic shock (life threatening condition from the body's response to infection). R79 's admission Minimum Data Set (MDS) assessment dated 2/23/22 indicated severe cognitive impairment, no care refusal behaviors, and required extensive assist of one to two for personal hygiene. R79's care plan dated 2/22/22, indicated R79 was limited in ability to maintain grooming/personal hygiene related to weakness. The plan of care included setting up resident with electric shaver and cue him to shave self. Provide assistance for facial hair removal as needed. On 3/7/22, at 6:11 p.m. R79 was observed seated	2 920	SPECIFIC RESIDENTS: Resident R15 and R18 affected by the alleged deficient practice remain within the facility. Resident R79 had discharged from the facility. Residents R14 and R18 have had their fingernails and facial hair trimmed per individual preference. Residents care plans have been updated on resident preferences and schedules for ADL's. OTHER RESIDENTS: All residents in the facility will have their facial hair and fingernails reviewed for preferences and completed if needed. All residents care plans will be updated to reflect resident's individual preferences and daily/weekly schedule for completion of tasks. Resident's preferences will be reviewed quarterly per the MDS schedule for preference changes and to assure proper supply for completion of facial hair and nails. Director of Nursing or designee will provide education on resident preferences and care plan will be completed for all licensed associates by April 4, 2022. MONITOR: The Director of Nursing or Designee will audit the completion of resident preferences relating to facial hair and fingernails for eight residents for four weeks. Then audit four residents weekly for an additional two weeks. Results will be provided to Quality Council.	

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2 920	Continued From page 12 in a wheelchair with whiskers present on lower face and neck approximately 1/3 inches in length. During interview a family member (FM)-E indicated the resident hasn't been shaved over the past 3 days and the last time he was shaved, she brought his razor from home and shaved him herself. R79 indicated he would like to be shaved at least every other day. On 3/8/22, at 2:43 p.m., R79 was lying in bed with no whiskers present. During interview, R79's FM-E indicated they didn't offer to shave him so she shaved him today. FM-E added no one has offered to shave him since he has been here for 20 days and this is the second time she has shaved him. FM-E stated she brought his razor from home both times and will take it home again so it doesn't get lost. FM-E added they have razors here so so doesn't know why they don't shave him. During observation and interview on 3/9/22, 7:19 a.m., R79 was in dining room in his wheelchair with whiskers present on lower face and neck approximately, 1/8" in length. R79 indicated staff washed him up this morning and changed his clothes, but did not offer to assist him with shaving. During interview on 3/9/22, at 7:48 a.m., nursing assistant (NA)-B indicated she was unsure if they have any razors at the facility and asked registered nurse (RN)-C. NA-B indicated residents should be shaved daily. During interview on 3/9/22 at 7:50 a.m., RN-C indicated the facility asks family members to bring in a razor as the facility does not provide an electric razor. RN-C indicated they do have some small disposable razors with blades, but has	2 920		

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2 920	Continued From page 13	2 920		

never witnessed staff use them. RN-C added that R79 had scabs on his face when he first came to the facility, but have been healed for about the last week and R79 should be shaved daily.

On 3/10/22, at 9:05 a.m., R79 was observed in the dining room with two days of whiskers present.

During interview on 3/10/22, at 9:07 a.m., NA-C indicated families are supposed to bring razors in for residents and they are educated on this when the resident is admitted to the facility. NA-C stated they used to have a razor, but is unsure what happened to it, and are not allowed to use any blade type of a razor. NA-C indicated she was not aware R79's family member was shaving him.

During interview on 3/10/22, at 9:45 a.m., RN-B indicated the unit does not have an electric razor and the facility only provides a tooth brush, tooth paste and a few other items. RN-B indicated on admission, they will ask the family member to bring one from home. RN-B indicated FM-E brought one in a few days ago and took it upon herself to shave R79. RN-B indicated yesterday a request was made for the FM-E to bring R79's razor from home and leave it at the facility and added R79 was told if he doesn't get shaved, RN-B will shave him. RN-B indicated R79 had scabs and lesions on his face initially but they are now healed.

On 3/10/22, 1:43 p.m. an interview with the director of nursing (DON) indicated when residents are admitted from the hospital, the hospital provides a list of items for the family to bring to the skilled nursing facility, which includes

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2 920	Continued From page 14 an electric razor. The DON did confirm residents should be shaved daily and it is a standard of care. R18 R18's facesheet printed on 3/10/22, indicated diagnoses of dementia and Alzheimer's disease. R18's quarterly Minimum Data Set (MDS) assessment dated 12/15/21, indicated R18 had severe cognitive impairment and required extensive assistance of one staff for personal hygiene. R18's plan of care initially reviewed upon entrance indicated R18 needed assistance of one staff to perform grooming/personal hygiene as a result of dementia. In addition, R18 was to receive a bath/shower in which staff were to provide nail care to hands. This care plan focus area was started on 9/17/20 and did not specify measures to manage chin hair. During an observation on 3/7/22, 2:59 p.m., R18 was sitting in a wheelchair in her room. Observed approximately six long chin and right cheek hairs, one quarter inch to approximately two inches in length, gray or white in color. Also observed long, manicured fingernails with dark material underneath the nails. Nails had been polished, but some polish was missing from each finger. Dark reddish material was noted to have dripped down and dried on the outer aspect of R18's little finger, right hand. During a telephone interview on 3/7/22, at 7:11 p.m., family member (FM)-C stated she was aware of R18's chin and cheek hairs, and stated she noticed them the last time she was there, adding "Mom wouldn't have liked that."	2 920		

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2 920	Continued From page 15 During an observation on 3/8/22, at 1:38 p.m., R18 was lying in bed sleeping. Chin and cheek hairs still present. During an interview on 3/8/22, at 1:56 p.m., nursing assistant (NA)-D was asked about documentation of resident baths and provided a binder with completed bath sheets. For R18, there were two bath sheets dated 2/2, and 2/23/22. There was a spot to document "nail care completed -- yes or no." This was blank on both sheets. There was no spot to document if chin hair was addressed. NA-D was not able to say if R18 had a bath since 2/23/22, as bath sheets were not always placed in the binder. When asked about shaving female residents, NA-D stated staff shaved chin hairs when they saw them and families were to provide an electric razor for this purpose. During an interview and observation on 3/8/22, at 2:08 p.m., together with NA-D, went to R18's room where R18 was resting in bed. NA-D confirmed the long chin and cheek hairs, stating that should have been taken care of on bath day. NA-D looked in the dresser next to bed and in the bathroom for an electric razor but there was none. NA-D looked at R18's fingernails and acknowledged dark material under the nails and peeling nail polish. NA-D stated that chin hair and nail care should both be done on bath day, or whenever staff noticed it. During an interview and observation on 3/8/22, 2:44 p.m., together with licensed practical nurse (LPN)-F, went to R18's room where R18 was resting in bed. LPN-F looked at R18's nails and chin hair. LPN-F picked up both hands and looked at front and backs of nails, stating "they	2 920		

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2 920	Continued From page 16 need to be cleaned...it's probably food." LPN-A acknowledged R18's chin hairs and stated they were usually taken care of on bath day or whenever it was noticed by staff outside of bath day. LPN-F looked in the bathroom for an electric razor, but couldn't find one, adding that family needed to provide it. During an interview on 3/8/22, at 2:53 p.m., registered nurse (RN)-A stated nail care was done with every bath; that was the minimum expectation, and also anytime staff noticed they were dirty. RN-A looked at bath sheets for R18 acknowledged there was nothing documented for R18's nail care for baths on 2/2, and 2/23/22. RN-A stated R18's family member preferred they plucked R18's chin hairs, adding that any staff could notice they need to be plucked..."It's a dignity issue; anyone, any shift, can notice and report this. I've plucked them myself." RN-A verified that managing R18's chin hair was not identified in her plan of care. R18's plan of care edited on 3/9/22, by registered nurse (RN)-A indicated R18 had facial whiskers and wanted staff to pluck them with a tweezer when they were long. During an interview on 3/10/22, at 9:25 p.m., the director of nursing (DON) stated she expected that on bath day, that chin hair and fingernails were looked at and cleaned, adding that R18 tended to eat with her fingers..."We expect staff clean her hands after eating." The DON confirmed that all staff were responsible for identifying chin hair and dirty fingernails and speaking to the staff who can address it. R15 R15's face sheet printed 3/10/22, indicated R15	2 920		

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2 920	Continued From page 17 was admitted on 6/2015, and diagnoses indicated depression, dementia, muscle weakness, and deformity of left finger. R15's quarterly Minimum Data Set (MDS) assessment dated 12/8/21, indicated severe cognitive impairment, no care refusal behaviors, required extensive assist personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands. R15's care plan dated 3/7/22, indicated R15 was limited in ability to maintain grooming/personal hygiene related to abnormality of gait, restless leg syndrome, muscle weakness, and intellectual disabilities, the care plan did not indicate interventions related to facial hair. On 3/7/22, at 2:28 p.m. R15 was observed seated in a wheelchair and skin area above upper lip with varied lengths (approximately 1/2 inch) black and brown whiskers and hairs. On 3/9/22, at 8:20 a.m. R15 was observed in the dining room seated in wheelchair well groomed, clean clothes, with varied lengths of black whiskers and hair above upper lip. On 3/9/22, at 8:26 a.m. an interview with nursing assistant (NA)-A indicated she assisted R15 with morning ADL cares this morning, and indicated R5 was dependent on staff for hygiene cares and shaving. NA-A stated R15 was expected to be shaved during morning cares, indicated R15 hairs above her upper lip were long and needed shaving, and further confirmed staff or herself had not completed the task for R15. Review of R15's progress notes identified there	2 920		

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2 920	Continued From page 18 was no mention of any refusal of care. On 3/9/22, 1:43 p.m. an interview with the director of nursing (DON) confirmed she would expect residents to be shaved during cares or anytime a resident is identified with facial hair and indicated shaving was a standard of care. Facility policy titled Activities of Daily Living (ADL), dated 2021, indicated residents would be provided with care, treatment and services to maintain or improve their ability to carry out ADL's. Residents unable to carry out ADL's independently would receive services necessary to maintain grooming and personal hygiene, including bathing, dressing, grooming and oral care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff on completing routine grooming for residents requiring assistance. The DON or designee could review and revise grooming policies as needed. The DON or designee could perform audits to ensure the policies are being followed. The results of those audits could be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as	2 965		4/4/22

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2 965	Continued From page 19 determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that individual food preferences/food choices were assessed for 5 of 5 residents (59, R232, R53, R37 and R56) reviewed for food preferences. Findings include: R59's quarterly BIMS (brief interview for mental status) assessment on 2/9/22, indicated mild cognitive impairment. R59 was admitted in 2021. During an interview on 3/7/22, at 3:16 p.m., when asked about meals and food, R59's family member (FM)-G stated, "Supper meals are skimpy", and R59 would like bigger portions. In addition, FM-G stated R59 doesn't like fish and received fish last week. FM stated no one had asked her or R59 about food preferences, likes and dislikes. R232 R232's admission BIMS assessment dated 3/6/22, indicated R232 was cognitively intact. R232 was admitted within the past 30 days During an interview on 3/7/22, at 4:49 p.m., when asked about meals and food, R232, who ate in her room, stated breakfast and lunch were good, but supper was fair. "I could have a little more	2 965	SPECIFIC RESIDENTS: Residents R232, R37, R56 and R59 affected by the alleged deficient practice remain in the facility. Resident R53 affected by the alleged deficient has discharged. Resident's meal preferences have been reviewed by the culinary director. All residents preferences on meals have been updated in Mealsuite and their care plan. OTHER RESIDENTS: All residents within the facility will have meal preferences reviewed. All new admissions will meet with the culinary director or designee with in the first seven days to review meal preferences. Resident's preferences will be documented in Mealsuite and their individual care plan. Quarterly at per MDS schedule residents meal preferences will be reviewed and updated. Director of Culinary Services will provide education to all associates on the procedure for culinary assessment and documentation on meal preferences and care planning by April 4, 2022. MONITOR: The Director of Culinary or Designee will audit four residents for the first four weeks to assure culinary assessment and meal preferences are	

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2 965	Continued From page 20 individualized food." R232 received a polish sausage on a white hot dog bun for supper and stated she had never had so much processed meat. Observed that the sausage was eaten and the hot dog bun was still on her plate. R232 stated "I don't eat white bread." R232 stated no one had asked her about her food preferences. R232's paper diet slip on her table had no food preferences, likes or dislikes listed on it. There was no documentation in the electronic medical record (EMR) of an interview by culinary staff regarding food preferences, likes and dislikes. R53 R53's admission BIMS assessment dated 2/13/22, indicated R53 was cognitively intact. R53 was admitted on 2/7/22. During an interview on 3/7/22, at 4:05 p.m., when asked about meals and food, R53, who ate in her room, stated food did not taste good; always canned fruit, no flavor and meat was dry. During an interview on 3/7/22, at 5:50 p.m., R53 had eaten a polish sausage, but not the bun, stating, "Too much bread here." Had canned pears for dessert, stating "Too much canned fruit. I'm used to eating fresh fruit." R53 stated no one had asked her about food preferences, such as likes and dislikes. R53's diet card indicated an allergy to fish, but did not indicate food preferences, likes or dislikes. There was no documentation in the EMR of an interview by culinary staff regarding food preferences, likes and dislikes. R37 R37's quarterly BIMS assessment dated 1/26/22, indicated R37 was cognitively intact. R37 was admitted in 2020 R56	2 965	documented. Then will audit two residents weekly for an additional two weeks. Results will be provided to Quality Council for reassessment.	

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2 965	Continued From page 21 R56's quarterly BIMS assessment dated 2/9/22, indicated R56 was cognitively intact. R56 was admitted in 2020. During resident council meeting interview on 3/8/22, at 3:56 p.m., R37 and R46 were in attendance. When asked if staff talked to them about food preferences, likes, dislikes and portion sizes, R37 stated "no one has ever asked me likes and dislikes." R56 stated "we haven't had the opportunity to do that at all." During an interview on 3/9/22, at 9:38 a.m., culinary services supervisor (CSS)-A stated someone from culinary services met with new admissions, adding they had a likes and dislike chart and they brought it along to ask residents what types of meals they liked. CSS-A stated the culinary services director (CSD)-B met with residents right away unless he delegated it to CSS-A. CSS-A was asked for documentation that R53, R59 and R232 were asked about food preferences, likes and dislikes, and also copies of various menu's that were observed during the kitchen tour. On 3/9/22, at 4:06 p.m., CSS-A and the administrator provided copies of various menu's as requested, but not documentation that R53, R59 and R232 were asked about food preferences, likes and dislikes. During an interview on 3/10/22, at 9:05 a.m., the administrator was informed that despite requesting both verbally and in writing, documentation that R53, R59 and R232 were asked about food preferences, it had not been received. During an interview on 3/10/22, at 10:05 a.m.,	2 965		

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2 965	Continued From page 22 while speaking to registered nurse (RN)-A in a nurses office, CSS-A and the administrator came in and stated culinary staff met with residents, filled out a sheet regarding food preferences, including likes and dislikes and the entered this information into an electronic program called Meal Suite, then discarded the sheet. CSS-A and the administrator were asked to provide documentation of this by printing the information from Meal Suite that indicated who met with the resident, on what date, and what food preferences, likes and dislikes were documented. CSS-A and the administrator were asked to select five recent admissions to demonstrate that this was being done. RN-A overhead the conversation and provided a form that appeared to have been copied many times. The form was crooked and the heading was cut off. The word "date" followed by a line were partially visible at the top. RN-A stated the facility used to use this form. The form had three columns indicating different types of food: dairy, meat, fish, soups, beverages, vegetables/starches and cereal. After each of the food columns were two blank columns with headings of likes and dislikes. In addition, there were spots to write in notes about portion size, food allergies and intolerance's, cultural/ethnic/religious food requests. At the bottom of the form it indicated to fill out and return to "CDM" (certified dietary manager). CSS-A and the administrator looked at the form, but indicated they were not aware of it. During an interview on 3/10/22, at 11:16 a.m., CSS-A was again asked if residents were being interviewed by culinary staff to determine food preferences, likes and dislikes. CSS-A stated neither he nor CSD-B had been doing this. CSS-A acknowledged the culinary staff should know resident food preferences, likes and dislikes in	2 965		

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2 965	Continued From page 23 order to provide a positive meal experience, adding "I think we should be doing it - food is important to residents." During an interview on 3/10/22, at 1:55 p.m., the administrator provided additional documents showing evidence that food, in general, was discussed at quarterly care conferences, however, the administrator was not able to say if culinary staff meet with residents individually to ascertain their food preferences, likes and dislikes. During an interview on 3/10/22, at 3:48 p.m., the administrator stated she believed residents were asked about food preferences at quarterly care conferences which were lead by social services, and which culinary staff did not attend. The administrator stated care conferences for newly admitted residents occurred within about five days of admission and if a resident brought up a significant food concern, then an in-depth interview would occur with culinary services. The administrator was informed the facility policy titled: Initial Visit/Diet History for Community Admissions, dated 2012, indicated the culinary service director/dietician/designee would visit all residents upon admission and document the summary of the visit and the outcome in the residents medical record. Information would include a request for food and beverage preferences and dislikes; special needs, concerns or questions that needed to be addressed. The administrator stated the former culinary services director used to meet with new residents, but was unaware if CSD-B continued the practice. The administrator stated she would look into this. Facility policy titled Initial Visit/Diet History for	2 965		

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2 965	Continued From page 24 Community Admissions, dated 2012, indicated the culinary service director/dietician/designee would visit all residents upon admission and document the summary of the visit and the outcome in the residents medical record. Information provided would include: a welcome to the facility, introduction of culinary services director and department, time of meals and between meal nourishments, request for food and beverage preferences and dislikes, review diet order and special needs, concerns or questions that needed to be addressed. This admission visit was to be documented in the residents medical record. SUGGESTED METHOD OF CORRECTION: The Dietary Director and/or Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure each resident receives food that accommodates his/her allergies/intolerance's/preferences. The Dietary Director and/or Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Dietary Director and/or Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		4/4/22

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21375	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an unvaccinated resident socially distanced during congregate dining for 1 of 1 unvaccinated resident (R54) residing on the Kindle neighborhood. This had the potential to affect all 5 residents who sat at the same table with R54 during dining. Findings include: R54's Resident Face Sheet printed 3/10/22, indicated R54 was admitted 2/8/22, and diagnoses including COVID-19 and type II diabetes. R54's care plan printed 3/10/22, directed to educate staff, resident, family and visitors of COVID-19 signs and symptoms and precautions. The care plan further directed to follow facility protocol for COVID-19 screening/precautions. R54's Covid 19 Vaccine Consent form, signed/dated 2/8/22, indicated R54's representative declined the Covid 19 vaccine for R54 and understands the risk, benefits and consequence of declination. The care plan did not identify an intervention of social distancing. On 3/9/22, at 12:00 p.m. R54 was observed seated in the Kindle neighborhood dining room at a rectangular table approximately 4 x 6 feet in diameter. R54 was seated centrally on the 6 foot side of the table with five other residents (R43 ,R53, R63, R74, R77) seated around the table with him; all residents were without a mask and	21375	SPECIFIC RESIDENTS: Resident R54 affected by the alleged deficient practice has discharged from the facility. Immediate education was provided to licensed associate on procedure for social distancing of residents that are not fully vaccinated. All residents in the facility were monitored for signs and symptoms of illness relating to resident R54. No residents in the facility have had signs or symptoms of Covid-19. OTHER RESIDENTS: All current short term residents will be reviewed for full compliance of Covid-19 Vaccination status and all new admissions are screened upon admission. If a resident is not fully up to date with Covid-19 vaccination an educational sign will be placed on his/her medication cabinet where their face mask is located. The educational sign will state the guidelines for a resident that is not fully vaccinated. This will include but limited to the resident must wear a mask at all times when in the presence of another peer and if unable must, maintain social distance of 6 feet at all times. This includes that the resident is unable to dine with peers at the same table and is recommend to enjoy all meals in his/her bedroom. If the resident must dine in the dining room they must eat at a separate table and maintain social distance of 6 feet at all times. This sign will also be an additional alert for staff on resident's vaccination status along with the information on their face sheet. Director of Nursing will provide education to all	

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21375	Continued From page 26 were eating their lunch meal. R54 was not socially distanced 6 feet or greater, from the other five residents. Staff were not observed to offer or coach R54 to socially distance six feet or greater as recommended by the CDC. On 3/10/22, at 11:52 a.m. R54 was observed seated in the Kindle neighborhood dining room at the same rectangular table with three other residents (R53, R63, R74); all were unmasked and eating their lunch meal. R54 was not socially distanced 6 feet or greater from the other three residents nor did staff offer or coach R54 to socially distance six feet or greater. On 3/10/22, at 11:56 a.m. licensed practical nurse (LPN)-E stated being unaware of any residents in the Kindle neighborhood who were not vaccinated. LPN-E confirmed upon admission unvaccinated residents were quarantined to their room and on droplet precautions for 14 days following admission. When their 14 days were up, unvaccinated residents were expected to wear a mask and social distance when leaving their room. On 3/10/22, at 1:40 p.m. LPN-C/infection preventionist (IP), confirmed she had not provided any guidance to unvaccinated residents other than encouraging them to wear a mask when leaving their own neighborhood. LPN-C/IP confirmed the current CDC guidance and facility policy indicated unvaccinated residents were to socially distance six feet or greater. On 3/10/22, at 3:52 p.m. director of nursing (DON) confirmed R54 should have been social distancing in the dining room when eating meals. The policy titled, Benedictine Visitor Guidance	21375	associates on the procedure for Infection and Prevention relating to resident Covid-19 vaccination status by April 4, 2022. MONITOR: The Director of Nursing or Designee will audit 6 residents on vaccination status and following MDH guidelines on mask usage and social distancing weekly for the first four weeks. Then audit three residents twice weekly for an additional two weeks. Results will be provided to Quality Council for reassessment.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 27 Summary, updated 12/30/21, indicated: Residents who are unable to wear a mask due to a disability may attend communal activities if they are able to social distance. If possible educate the resident on the core principles of infection prevention. Staff should provide frequent reminders to adhere to infection prevention principles. The Center for Disease Control (CDC) "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" updated 2/2/22, recommended source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission or who have: Are not up to date with all recommended COVID-19 vaccine doses. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could inservice nursing staff to appropriately implement social distancing of unvaccinated residents during dining. The DON or designee could review and revise dining policies as needed to ensure appropriateness. The DON or designee could perform audits to ensure the policies are being followed. The results of those audits could be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		