May 7, 2018

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

Subject: Koda Living Community - IDR
CMS Certification Number (CCN) 245426
Project # S5426029

Dear Mr. Vandergon:

This is in response to your letter of January 11, 2018, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tags F580, F641, F684, and F689 issued pursuant to the survey event XLM011, completed on December 15, 2017.

The information presented with your letter, the CMS 2567 dated December 15, 2017 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F580 D Level: 42 CFR *§483.10(g)(14) Notification of Changes*
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is—
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is—
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

Summary of the facility's reason for IDR of this tag.
The facility provided a time line and follow up treatment they provided to resident R76 while in the facility before she was transferred to an acute care hospital for treatment.

Summary of findings
R76 had been discharged from the facility to an acute care hospital for care. Review of R76's record identified R76's physician and nurse practitioner were notified at times during R76's stay at the NH. During this stay there were other times when R76 was having symptoms of increased pain for several days and had a decline in her overall status. During these episodes the facility had not contacted the physician or NP to change the plan of care for R76.

This is a valid deficiency at this tag and at the correct scope and severity of D, isolated incident, no actual harm with potential for more than minimal harm.

F641 D Level: 42 CFR *§483.20(g) Accuracy of Assessments.*
The assessment must accurately reflect the resident's status.

Summary of the facility's reason for IDR of this tag.
The resident R13 does not qualify for a Level 2 screening and did not have a mental condition other than the physician ordered Seroquel for paranoid thoughts and delusions.

Summary of findings
The facility did not code the MDS appropriately, as R13 did not have a diagnosis of personality disorder per the chart review. The facility agreed they coded the MDS incorrectly as identified by the tag.

This is a valid deficiency at this tag and at the correct scope and severity of D, isolated incident, no actual harm with potential for more than minimal harm.

F684 G Level: 42 CFR *§ 483.25 Quality of care*
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Summary of the facility's reason for IDR of this tag.
The facility provided a time line with treatment they provided to resident R76 while in the facility before she was transferred to an acute care hospital. The increase in her creatinine was related to the Multiple Myeloma diagnosis R76 received after she discharged from the nursing home to the acute care facility.

Summary of findings
R76's Nursing Home Pain Management- Pain Assessment, dated 9/12/17, identified R76 was not in pain, and was blank for what level of pain was acceptable to the resident. The assessment identified R76's characteristics of pain as aching, even though the nursing notes identified R76 was having stabbing, and significant pain. The onset of pain, was blank and identified R76 received scheduled pain medication of aspercreame, but did not identify Tylenol, Tramadol or Lidoderm which was scheduled and administered since admission to the facility on 9/5/17. The assessment identified the resident stated it was difficult to sleep, rates her worst pain as an 8 out of 10, but the verbal description scale was left blank even though R76 identified her pain was located in resident back and left arm. The facility had not completed a comprehensive pain assessment, to determine the most effective pain management plan even though R76's pain continued to escalate.

R76's hospital discharge note 9/5/17, before admission to the nursing home on 9/5/17, identified kidney function, labs of BUN and Creat were both within normal limits. R76's BUN and Creat labs increased while being a resident at the NH, identifying worsening kidney function.

This is a valid deficiency at this tag and at the correct scope and severity of G, isolated incident, actual harm.

F689 G Level: 42 CFR *§483.25(d) Accidents.*
The facility must ensure that –
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Summary of the facility's reason for IDR of this tag.
Resident had been care planed on admission he was high risk of falls related to prosthetic hip dislocation frequently prior to admission, and was wearing his gripper socks at all times.

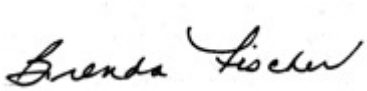
Summary of findings
R48 had seven falls while in the facility which occurred between 1:15 am and 11:45 a.m.. Six of these falls occurred between 1:15 a.m. and 7:40 a.m., with only one fall occurring at 11:45 a.m. All of these falls occurred in the resident's room. On three separate occasions, R48 told the staff he needed to paint a door, work in the grain bins or was getting hay as the rational for getting up. Review of R48's face sheet identified his previous occupation a farmer. Although R48 had a pattern of falls, occurring in his room during the early morning hours (was a farmer), the facility did not comprehensively look at the fall pattern times nor location to determine a effective fall intervention plan and implement these interventions to decrease his fall risk. R46 sustained fractures, and lacerations as a result of these falls and at no time did he suffer from a prosthetic hip dislocation before or after these falls that occurred in the facility.

This is a valid deficiency at this tag and at the correct scope and severity of G, isolated incident of actual harm.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,



Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
3333 West Division St, Suite 212
St. Cloud, MN 56301
Telephone: 320-223-7338 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gary Nederhoff, Rochester District Office Unit Supervisor

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XLM0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00644

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245426**
2.STATE VENDOR OR MEDICAID NO.
(L2) **046492200**

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

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

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

6. DATE OF SURVEY **02/13/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **79** (L18)
13.Total Certified Beds **79** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Vicky Hamersma, HFE II 03/07/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 03/07/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245426

March 7, 2018

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

Dear Mr. Vandergon:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 1, 2018 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered

March 7, 2018

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

RE: Project Number S5426029

Dear Mr. Vandergon:

On January 3, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 8, 2018. (42 CFR 488.422)

We also recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy were being imposed:

- Civil money penalty for the deficiency cited at F684 & F689. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on December 15, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 13, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 12, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 15, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 1, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 15, 2017, as of February 1, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 1, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty for the deficiency cited at F684 & F689 be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XLM0

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7. On-Site Visit **9. Other**
8. Full Survey After Complaint

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

6. DATE OF SURVEY **12/15/2017** (L34)

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2 AOA 3 Other

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FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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	79			
(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date :
Danette Bakken, HFE II 01/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 01/29/2018 (L20)

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

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23. LTC AGREEMENT BEGINNING DATE
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25. LTC EXTENSION DATE:
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A. Suspension of Admissions:
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B. Rescind Suspension Date:
(L45)

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02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

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(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 3, 2018

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

RE: Project Number S5426029

Dear Mr. Vandergon:

On December 15, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567 and/or Form A, whereby significant corrections are required.

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

> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and
>
> Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 8, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalties for the deficiencies cited at F684 and F689. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 15, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 15, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	12/15/2017

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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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted December 11, 12, 13, 14, & 15, 2017, during a recertification survey. The facility is not in compliance with the Appendix Z Emergency Preparedness Requirements. The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		1/24/18

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

Electronically Signed | 01/11/2018

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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failedto ensure they had implemented emergency generator inspection/testing in accordance with the requirements. This had the potential to affect	E 041	EO41-Hospital CAH and LTC Emergency Power SPECIFIC RESIDENTS: All residents affected by alleged deficient practice.	

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E 041	Continued From page 3 all residents, staff and visitors of the facility. The findings include: On facility tour between 11:00 AM and 2:00 PM on 12/13/2017, during documentation review, documentation could not be located to show that the weekly inspection on the emergency generator had occurred during the period of July 24, 2017 to December 1, 2017 and the emergency generator had not had a monthly load test during the months of August, September, and October, 2017. This deficient practice was verified by the Facility Maintenance Director.	E 041	OTHER RESIDENTS: The missing documentation was due to employee failure. Corrective action has been taken with employee. The monthly generator testing and the weekly inspection are back on schedule as required. A new documentation book with tabs in the correct order for the State annual inspection process will be used going forward. There is a tab for each item that needs periodic testing or inspection The Director of Environmental Services will audit the book periodically to insure that testing and inspection occur at the proper intervals, and is documented correctly.	
F 000	INITIAL COMMENTS On December 11, 12, 13, 14 and 15, 2017, a standard recertification survey was conducted. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		1/24/18

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F 554	Continued From page 4 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess a resident's self administration of medications for 1 of 1 resident (R60) who requested to have over the counter medications at his bedside. Findings include: R60 had been interviewed on 12/11/17, at 6:04 p.m. and stated, "I have a concern about pain. Yesterday I had pain, I felt like I was having a heart attack, they brought me Tums and it did not help." R60 stated he called [family member-A] and requested to bring in gas-x as that was what had worked at home. On 12/12/17, at 9:44 a.m., R60 stated, "[family member-A] arrived to my room with the gas-x almost sooner than the nurse did." R60 stated he asked staff if he could have the medication in his room so he could have it whenever it was needed. R60 stated he was told residents were not allowed to have medications in the room because of "rules". R60 additionally stated he has requested a cream used at home for dry skin and scalp. He has requested to get it from the nurses approximately twice a week. R60 stated he was again told it was about the rules. "They won't break the rules." R60 stated they were putting an oil on his forehead instead. A resident progress note dated 12/10/17, at 1:05 p.m., indicated the resident had asked to receive	F 554	F554- Resident Self Administration Medications-Clinically Approp SPECIFIC RESIDENTS: Resident R60 affected by the alleged deficient practice. RN did a self-administration assessment and found that R60 to be competent to self-administer over the counter medications. Self-administration by R60 has been completed and implemented. OTHER RESIDENTS: We will continue with the self-administration of medications assessment on every admission and complete the comprehensive assessment. As well with any resident who verbally expresses that they want to begin to administer medications at any time during their stay within the facility. At each care conference we will also ask if a resident would like to start self-administering any medications. Education will be given on January 22, to all KLC associates and a skills fair for all licensed associates on January 30 2018 and to all licensed staff. MONITOR: The Director of Nursing or Designee will audit all new admissions for the first four weeks to assure initial assessment is completed. Then two residents weekly for one month, then one resident weekly for one month if compliant. Results will be provided to Quality Council for reassessment.	

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F 554	Continued From page 5	F 554		

a daily multivitamin, but had gone on to talk about other vitamins, Vitamin C, vitamin B, and Vitamin D. The note indicated the nurse noticed an OTC (over the counter) med (unidentified) in R60's room, which had been removed and locked up.

R60's quarterly/annual body audit dated 11/21/17, identified the back of R60's head was dry and scaly and had a skin eruption.

R60's current physician orders identified "ok" for resident to use home supply of dandruff shampoo.

On 12/14/17, at 9:07 a.m., R60 was asking RN-G for gas-x, stating he wanted to be prepared. R60 stated sometimes it felt like a heart attack. RN-G informed R60 she would check for an order for the gas-x. R60 stated they have the medication here under padlock. RN-G reviewed R60's record and stated there was no order for gas-x. When asked if R60 had a bottle of gas-x in the facility, RN-G was unsure and checked the medication cart, medication storage room and medication cupboard in R60's room. R60's locked medication cupboard in his room had a bottle of gas-x inside with a sticker, which read home supply. RN-G stated they were probably waiting on an order for it. RN-G went to the nurse's office and asked R60's primary physician if an order had been requested for the gas-x. R60's physician stated an order would be written for the gas-x.

On 12/14/17, at 11:36 a.m., the director of nursing (DON) in regards to the gas-x, said that I would check to see if he had an order for the medication and if did not proceed to obtain an order. DON verified R60's body audit dated 11/21/17, and stated R60 was receiving a special shampoo, but

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F 554	Continued From page 6 she did not see a cream being applied on treatment record. On 12/15/17, at 9:31 a.m., observation with registered nurse (RN)-F of R60's scalp identified dry skin on the back of R60's head. R60 stated sometimes it itched. RN-F stated R60 had mineral oil used before, and reported he had tried something at home. RN-F reviewed R60's orders and stated he had an order for dandruff shampoo, but no order for oil. R60 stated he did not use oil, it was a cream that worked at home. RN-F stated she did not recall R60 requesting to use a cream before, but would check with the physician. A policy regarding resident's keeping medications in their room was requested, but not provided.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		1/24/18

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F 580	Continued From page 7 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to immediately consult with the residents physician for a need to alter treatment significantly for 1 of 1 residents (R)-76 reviewed for hospitalization. This practice resulted in harm due to R-76 failure for pain to improve and worsening symptoms and new symptoms	F 580	F580-Notify of Changes SPECIFIC RESIDENTS: Resident R76 affected by the alleged deficient practice. Resident has discharged from the facility. OTHER RESIDENTS: If a significant change is occurring in the resident□s medical/mental condition that requires IDT	

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F 580	Continued From page 8 developed such as dehydration. The findings include: R-76 admitted 9/5/17 with a diagnosis of left arm humerus fracture (FX), collapsed vertebra, age related osteoporosis and other chronic pain. Care area assessment dated 9/12/17 reads; Staff will administer all pain medications as directed by MD. Staff will monitor for effectiveness of medication. Staff will attempt non-pharm interventions prior to administering PRN medications. Notify MD of changes or uncontrolled pain. Review of care plan reads problem resident had complaints of acute pain r/t left humerus FX and collapsed vertebra. Interventions are to evaluate effectiveness of pain management intervention. Notify MD/NP if ineffective of adverse side effects emerge, monitor, and record any complaints of pain. R-76 was receiving tramadol and Tylenol as needed for pain. Medications for pain had been given daily. R-76 had continuous complaints of pain since admission on 9/5/17 through 9/12 with no contact to a physician for the ineffectiveness of treatments. On 9/9/17 daughter in facility, updated staff the concern of current medication regimen was not covering the pain well. Staff told daughter discuss at appointment scheduled 3 days later. R-76 continued with pain daily with current pain medication treatment given. On 9/12/17 R-76 had the appointment noting	F 580	review or care plan revision the facility will notify physician within 24 hours of incident. Education will be given on January 22, to all KLC associates and a skills fair for all licensed associates on January 30 2018 and to all licensed staff. MONITOR: The Director of Nursing of Designee will do weekly audits for the first 4 weeks of the IDT meeting information to review all change of conditions are updated on the care plans and notification to physician has been completed. Results will be provided to Quality Council.	

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F 580	Continued From page 9	F 580		

facility provider with address pain.

Physician was not notify of this until in facility on rounds 9/14/17, 9 days of same medication regimen and R-76 continuous complaints of same, some progress notes to be extreme pain.

Physician made changes to medication regimen on 9/14/17. Pain continued after the medication change started 9/15/17 one day after change. No provider updated again with the daily complaints of pain until 9/19/17 (5 days later) when physician made another change in pain regimen.

9/19/17 in the evening, R-76 collapsed with assistance of two staff. No phone to physician.
9/21/17 a brace was added for support.
9/21/17 R-76 continues with pain and now not able to use right arm to preform activites of daily living or feed self.
9/22/17 received new orders for pain medications, continued to complain of pain and now needing a mechanical lift for transfers.
9/23/17 Daughter visiting noticed R-76 not at baseline. Staff told daughter R-76 had not urinated since the morning of 9/22/17. Daughter requested to be evaluated. R-76 admitted to hospital for dehydration and kidney failure.

Phone interview with family member (FM)-F on 12/15/17at 3:50 p.m. Reviewed time line of R-76 stay in the facility. FM-F stated they consulted with a family physician and felt they had to complete their own assessments on R-76.

Interview on 12/19/17 at 11:49 a.m. FM-F updated surveyor with the family felt they needed to keep in an eye on the cares of R-76 when the facility should have been doing it. Family felt the

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F 580	Continued From page 10 facility keep putting them in a pposition to assess R-76. Staff stated if you have a concern with the cares you can walk R-76 over to the Emergency room. Surveyor asked if she recalled the name of the staff member who said that. FM-F did not feel she could recall correctly. Review of policy titled: Change in a Residents Condition or Status reads; Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident medical/mental condition and/or status. A "significant change" of condition is a decline or improvement in the resident's status that, requires interdisciplinary review and/or revision of the care plan. Notifications will be made within twenty-four (24) hours of a change occurring in the residents medical/mental condition or status.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582		1/24/18

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F 582	Continued From page 11 specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 582	F582-Medicaid and Medicare	

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F 582	Continued From page 12 facility failed to provide adequate notification related to payment and services after Medicare A services had concluded. This affected 1 of 3 residents (R999) reviewed. Findings include: R999's Minimum Data Set (MDS) admission assessment dated 9/1/17, indicated the resident had been admitted to the facility on 8/25/17, to receive skilled services covered by Medicare A. On 9/18/17, R999's representative signed a Notice of Medicare Non-Coverage which indicated that R999's last Medicare covered day was 9/18/17. It is a condition of participation that all Medicare beneficiaries who are not discharging the facility at the end of a Medicare A stay, receive a Skilled Nursing Facility Advance Beneficiary Notice. This notice identifies an item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary, or custodial care. A copy of the Skilled Nursing Facility Advance Beneficiary Notice for R999 was requested but not received. During an interview on 12/15/17, at 3:20 p.m., registered nurse (RN)-C verified that she had been out on leave at that time and the Skilled Nursing Facility Advance Beneficiary notice had not been provided to R999 or her representative.	F 582	Coverages/Liability SPECIFIC RESIDENTS: Resident R999 affected by the alleged deficient practice. Resident has discharged from the facility. OTHER RESIDENTS: All residents in which Medicare part A ends and the resident remains in the facility are issued a SNFABN along with Medicare denials according to CMS guidelines. MDS coordinator will review requirements of SNFABN by January 22 2018. MONITOR: The Director of Nursing or designee will audit all residents who discharged part A and remain in the facility. Results of audits will be reported at daily reimbursement meeting starting on February 1 2018. Results also will be provided to Quality Council.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		1/24/18

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F 641	Continued From page 13 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Minimum Data Set (MDS) were accurately coded for 1 of 1 resident (R13) reviewed for a level II preadmission screen for mental illness. Findings include: R13 was admitted to the facility on 9/15/16. A preadmission screen completed on 9/13/16 did not indicate a need for a level II preadmission screen for mental illness. R13's medical record was reviewed and revealed a diagnosis of paranoid personality disorder had been added to R13's record on 11/17/16, after a physician's order was written for Seroquel (an antispychotic medication) 12.5 milligrams (mg) by mouth twice a day for paranoid thoughts and delusions. R13's MDS assessments dated 12/22/16, 3/23/17, 6/1/7, and 9/21/17 were coded to reflect a diagnosis of psychotic disorder. During an interview on 12/17/17, at 9:35 a.m. registered nurse (RN)-B stated whoever put the diagnosis of paranoid personality disorder into the computer system was not qualified to make that diagnosis. RN-B stated R13 did not have a psychotic disorder and stated the MDS assessments had been coded in error. RN-B stated the diagnosis of paranoid personality disorder was removed from the list of diagnoses from the face sheet on 12/13/17.	F 641	F641- Accuracy of Assessments SPECIFIC RESIDENTS: Resident R13 affected by the alleged deficient practice remains in facility, after assessment it was determined that resident does not meet requirements for a level two screening. OTHER RESIDENTS: The facility will ensure that all level two screenings are completed if needed on any admission or readmission. Social Services will review the requirements of a level two screening by January 22. MONITOR: The Director of Social Services or Designee will ensure that all PAS□s are completed and that any level two screenings are completed. Results will be provided to Quality Council.	

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F 641	Continued From page 14 During an interview on 12/14/17, at 12:43 p.m. the director of nursing (DON) stated the staff member who inputted the order for the Seroquel would have added the ICD-10 codes of paranoid personality disorder. The DON stated a resident having paranoid thoughts and delusion did not mean a resident had paranoid personality disorder. The DON stated she was not aware R13 had a diagnosis of a psychotic disorder.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		1/24/18

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F 657	Continued From page 15 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan for weight loss needs for 1 of 1 resident (R17). Findings include: R17's care plan was not revised to address ongoing weight loss. The minimum data set (MDS) dated 9/29/17, indicated R17 was independent with eating and weighted 140 pounds, with a weight loss not prescribed by a physician. The monthly weight log identified a weight of 124.6 pounds for 12/17. This was a loss of 15.4 pounds in 3 months. R17's care plan for nutritional status edited 10/3/17, identified a goal to maintain her current ability. Interventions included to monitor/record weight monthly. The care plan also directed staff to provide high protein/high carbohydrate foods/fluids. In addition R17 was to have 8 oz of greek yogurt twice daily between meals, protein rich foods at all meals and arginard (supplement suitable for people who require a calorie restriction, and require additional supplements to promote wound healing)1 package po (by mouth) twice daily for wound healing. There was no revision of interventions or goals to address R17's weight loss. On 12/15/17, at 1:58 p.m. the director of nursing (DON) stated interventions should have been reviewed due to continuous weight loss and the last time interventions were updated was in 6/17.	F 657	F657-Care Plan Timing Revision SPECIFIC RESIDENTS: Resident R17 affected by alleged deficient practice. R17□s care plan was updated and revised on December 26, 2017. OTHER RESIDENTS: The facility will identify other residents by requiring the nurse managers to run the Matrix Facility Activity report for new orders daily Monday-Friday and Saturdays will be run on Monday. This report will list all new orders for each resident and will cue the nurse to any significant change and/or care plans needs for each resident on their unit. Education will be given on January 22, to all KLC associates and a skills fair for all licensed associates on January 30 2018 and to all licensed staff. MONITOR: The Director of Nursing or designee will audit each manager Facility Activity Reports for completion and follow through on the care plan weekly for one month and monthly for 2 months. Results of audit will be reported at the monthly Quality council meeting.	

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F 684	Continued From page 16	F 684		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide needed care and or services, recognize risk factors, implement treatment according to care plan and failed to monitor and or revise resident's response to interventions for 1 of 1 resident (R76) reviewed for hospitalization. This practice resulted in harm due, R76 had increased pain and decline in condition. R76's face sheet indicated she'd been admitted to the nursing home on 9/5/17 with diagnoses including: left arm humerus fracture (FX), collapsed vertebra, age related osteoporosis and other chronic pain. An admission Minimum Date Set (MDS) dated 9/12/17 indicated R76 had a Brief Interview for Mental Status(BIMS) score of 11, which indicated she had moderate cognitive impairment. A subsequent MDS for R76, dated 9/19/17, identified a BIMS score of 7 which indicated severe cognitive impairment. A Care Area Assessment (CAA) dated 9/12/17, indicated R76's family had reported at admission	F 684	F684 Quality of Care SPECIFIC RESIDENTS: Resident R76 affected by the alleged deficient practice. Resident has discharged from the facility. OTHER RESIDENTS: Current resident□s pain assessments will be reviewed for completeness and will identify resident□s pain goal. All assessments will be completed by January 22, 2018. MONITOR: The Director of Nursing or designee will pull a random 15 residents per month on short term on accuracy of pain assessment and goals communicated effectively. Unit Managers will do a quarterly audit of 5 residents per month for an additional two months and bring findings to Quality Council.	1/24/18

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that R76 suffered from some forgetfulness. The CAA for pain indicated R76 had acute pain related to (r/t) the left humerus and vertebra FX. Interventions indicated staff would administer pain medications as directed by the medical doctor (MD), and would monitor the effectiveness of the pain medication. In addition, the CAA indicated staff would attempt non-pharmacological interventions prior to administering as needed (PRN) medications, and would notify the MD of changes or uncontrolled pain.

The care plan for R76 identified a problem with cognition and interventions for staff to: anticipate needs, encourage verbalization of feelings and concerns, to address concerns timely. Another problem area on the care plan indicated R76 had complaints of acute pain r/t left humerus FX and collapsed vertebra. Interventions were identified for staff to evaluate the effectiveness of pain management interventions, to notify MD/NP (nurse practitioner) if ineffective, or if adverse side effects emerged, and to monitor and record any complaints of pain including: location, frequency, intensity, effect of function, alleviating factors and aggravating factors.

The Physician's Order Report signed by the MD on 9/14/17, included: "...discharge potential: good, rehab potential: good, estimated length of stay less than 30 days." Medications listed included: "lidocaine patch on in the morning off at bedtime, Tramadol (a narcotic pain medication) 25 mg every 4 hours PRN (try non-pharmacological methods first: distract/divert with tasks, exercise, music, reminiscing, activities, assess for hunger, cold, toilet/reposition before giving, and chart tasks attempted and

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results.) Given left arm FX. Tylenol 325mg 2 tabs every 4 hours. Given per standing orders for pain or fever.

R76's Progress Notes indicated she had suffered from pain throughout her stay at the facility.

Review of administration of medications given identified:
tramadol 25mg as needed was administered
9/5 (day of admission) once
9/6 through 9/17 was given 3 times per day.
9/18 was given 4 times-for all reasons were for pain
With 41 times given staff only documented 19 times the results with 9 of those times mediation was not effective.
Tylenol 650mg as needed administered
9/5 (day of admission) once
9/7 was given 2 times
9/8 through 9/10 was given once
9/11 through 9/14 was given 2 times
9/15 given once
9/16 given 2 times
9/17 given once
9/18 given 2 times
With 20 times given staff only documented 9 times the results with 6 of those times medication was not effective.

Review of progress notes summarized:
9/5/17 at 11:26 p.m. R-76 able to verbalize needs and pain, R-76 long and short term memory appears primarily intact at this time.
At 11:33 left note for NP for care and maintenance of left arm splint, some discomfort at beginning of shift, meds given, has 101.1 temperature at 6:30 p.m. at 8:30 p.m.

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temperature was 99.
9/6/17 at 2:47 p.m. R-76 reports continuous pain to left shoulder
At 11:25 p.m. daughter here visitinig this evening, R-76 was noted to sitting at supper and just looked at her food, staff assisted to fed her and give her drinks, no attempt was made by R-76 to feed self, daughter states this is new for her. Food assessed to be able to use a fork or hands to feed self. Does make verbal noises with transfers which may be related to pain or anxiety with transfers. Pleasant and co op with cares.
9/7/17 at 3:37 a.m. R-76 complained of extreme 8 out of 10 scale pain, tramadol/Tylenol given, moans/screams with toileting/movement.
At 12:23 p.m. R-76 unable to walk due to back pain, unable to maintain standing position, requires w/c and assistance with mobility at this time.
9/8/17 at 3:39 a.m. R-76 does have verbal and nonverbal s/s/ of pain with activity, tramadol/Tylenol given.
At 2:16 p.m. R-76 continues to complain of severe lower back pain and left arm pain, rates pain 10/10 at its worst and currently 6/10.
At 11:29 p.m. fed supper by staff this evening, R-76 has significant increase in pain with movement, pain in both left arm and back. Daughter plans on discussing R-76 chronic pain with ortho doctor Tuesday.
9/9/17 at 11:57 a.m. R-76 continues to complain of extreme increase in pain in her lower back and left arm with transfers, rates pain 8/10 at its worst during shift and 0/10 while at rest in bed.
At 9:45 p.m. daughter here this evening states she does not feel that the tramadol is covering the pain well. Daughter is advised to discuss this with the doctor on Tuesday when R-76 has appointment, daughter stated she has some

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narco (pain medication) at home if that would help, assured the doctor she is currently see will be able to adjust and prescribe her medication as needed.
9/10/17 at 12:28 p.m. R-76 continues to complain of severe pain in lower back with transfers
At 10:18 p.m. R-76 continues to have significant back and left shoulder pain. States back hurts more than her arm.
9/11/17 at 4:30 a.m. R-76 slept a few hours of shift, but awoke with pain. Tramadol/Tylenol given because toileting transfers seemed almost impossible, seems to be almost painless while resting in bed.
At 12:20 p.m. R-76 reported back/left shoulder pain, rated pain 8/10.
9/12/17 at 11:41 a.m. care conference was held with R-76 and family, staff spoke to family regarding the increase in blood pressures and may be due to pain, has had a 4 pound decrease in weight since admission, discussed pain and possibly increase or change in pain medication. Encouraged family to discuss with the ortho doctor today at R-76 appointment.
9/12/17 at 12:05 p.m. Social services met with R-76, note reads R-76 did answer "yes" to having thoughts of being better off dead.
At 6:01 p.m. return from ortho appointment with orders for physical therapy, note reads humerus fracture is causing minimal achy pain. Most pain is from t-spine. Follow up with doctor for t-spine pain.
At 11:18 p.m. pain is primarily in the back. Appetite has been poor in the evening since admit. R-76 likes to rest on side while in bed to take pressure off her back.
9/13/17 at 3:09 a.m. R-76 yelled out and complained of pain in her back and left shoulder when transferred to the toilet around 2am.

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F 684	Continued From page 21 At 11:26 p.m. R-76 noted to have severe pain with movement. States feels better when laying or sitting still. R-76 has had a noted decline in appetite. Family left note for doctor regarding some of concerns regarding R-76. 9/14/17 at 2:56 p.m. doctor here on rounds. Received an order for fentanyl patch 12 mcg every 3 days, vitamin d3 1000 units daily and a lumbar x-ray r/t pain. Family took to x-ray. At 11:54 p.m. return from x-ray about 4:30 p.m. very fatiqued. R-76 at 50% of supper fed to her. 9/15/17 at 7:09 p.m. family expressed concerns about treatment for compression FX. NP faxed and returned fax received with update from NP as follows: compression fractures are very common and often very painful, especially initially. These are most often best treated with pain control and mobilization as tolerated. Copy given to daughter. 9/16/17 at 10:48 p.m. R-76 remained in bed all evening, using beside commode. Extreme pain noted with movement, transfers with 2 to 3 staff to maximize support and gentle movement. At 1:27 a.m. R-76 has extreme pain with movement, bedside commode used this shift, however did scream with pain with all motion, R-76 has already had as needed pain medications with little effect. R-76 much less pain once positioned and not moving. 9/17/17 11:03 a.m. note from physical therapy, R-76 increased c/o right hip pain this date with increased difficulties weight bearing right lower extremity with stand pivot transfer. Finding communicated with daughter and floor nurse. At 3:07 p.m. R-76 reported increased pain to right hip, stabbing like pain, rated pain 8/10 when sitting up and with transfers, R-76 sometimes screams with transfers. 9/19/17 12:31 p.m. R-76 complained of	F 684		

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generalized pain rated 5-8/10 during this shift.
At 4:02 p.m. telephone order from doctor to change tramadol to 50mg every 6 hours scheduled, start calcitonin 200iu daily alternating nostrils, gabapentin 100mg TID, Tylenol every 8 hours scheduled, d/c as needed dose and follow up with NP in morning if pain does not subside for possible increase in pain medications.
At 10:45 p.m. R-76 standing with 2 assist, lost control and collapsed.
9/20/17 at 6:13 p.m. R-76 calling out in pain with movement this shift, refused to get up for supper. R-76 claimed is in too much pain to get up and just wants to be left alone. Rated pain 10/10 in her back. R-76 also refused to eat her supper in bed, but did drink some of her ensure.
9/20/17 NP change ensure to one can by mouth twice daily and occupational therapy to evaluate wheel chair positioning (family reports slouching, not using arm due to "holding self up" in wheel chair.)
9/21/17 NP note Thoracic brace to be used as needed while oob (out of bed) for support and pain relief(compression FX)
9/21/17 at 1:38 p.m. R-76 continues to complain of severe pain in her back, upper arm, left hip and general joint aches. Medications given with very little relief. R-76 unable to use right arm to preform ADL's or feed self. R-76 severely self-limiting this shift.
9/22/17 at 7:11 a.m. R-76 requested to go the bathroom at 2am. R-76 is a 2 person assist with Hoyer for transfers (mechanical lift) R-76 did not want to use. Staff attempted transfer 2 times with the Hoyer. Once one inch off bed R-76 screamed in pain. Used bedpan with large void. Will continue to monitor and contact therapy regarding pain/discomfort with transfers.
At 10:57 a.m. new orders to discontinued

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tramadol and Tylenol. Increase fentanyl patch to 25mcg and start narco 5/325mg tabs 5 times daily scheduled, with a 2am PRN dose then change to every 4 hours as needed after 10days. Hold med if becoming to sedated.
9/23/17 7:56 p.m. R-76 resting well most of shift. Until shortly before dinner. R-76 began to experience pain not able to rate. Moaning audibly in pain even while at rest. Daughter visiting expressed concern the confusion and irritability R-76 had was too far from her baseline. Scheduled dose of narco given which has not appeared to have an effect on pain or irritability. Vitals record shows last recorded urination was around 9am on 9/22 and aides reported there has not been any this shift. R-76 skin tents and has a slight tremor in her right hand. On call physician contacted received order to send to emergency room for assessment.
9/24/17 at 12:06 a.m. received call R-76 will be spending the night in hospital due to renal failure. Bed hold signed.
9/25/17 at 1:48 p.m. received phone call will be transferred due to kidney failure and being anemic. Creatinine in 4.81 and hemoglobin 6.7.

Review of dismissal summary for medications does not have an order for Tylenol. The physician order review reads per facility standing orders. Review of standing orders titled Standing House Orders (SHO) for Symptom Management revised date June 2017. Reads: SHO will expire after three days and the provider will need to be contacted if there is a need for the order to be continued.
Order found to be continued without contact of provider per SHO

Interview on 12/15/17 at 04:32 p.m. registered

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nurse(RN)-L recalls pain never really got under control - back pain bothering her the most - scheduled tramadol every 6 hours 50mg - she seemed to respond less and less to pain medication. They started using a Hoyer because was not transferring well for protection of the staff and her. Started a fentanyl patch and changed to norco because not responding to tramadol - shortly after change went to hospital.

Interview on 12/15/17 at 3:18 p.m. Licensed practical nurse (LPN)-C was asked regarding the concern sheet the staff fill out for the provider to see and make notes. If surveyors would find them in the chart. LPN-C stated "no". Requested the document if any information was there. LPN-C stated they are left in the nurses station. Later updated no additional papers found verifying provider was updated with continued pain complaints.

Phone interview with family member FM-F on 12/15/17at 3:50 p.m. Reviewed time line of R-76 stay in the facility. FM-F stated wanted only facts to be shared and will keep opinions to self.

FM-F added they felt they had to come in do their own assessments to make sure R-76 was being cared for. FM-F requested several times to have labs completed but was denied the request with staff stating they were trying to get the pain under control first. FM-F commented the day R-76 went in to hospital they stepped out side to get some fresh air when R-76 requested not to go back in the facility. Family assessment completed after consulting a physician in the family for help. FM-F suspected R-76 was dehydrated after completing a pinch test on the arm. FM-F requested the physician be called for

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an evaluation. Staff told FM-F providers do not come over to evaluate. Order was requested to transport to emergency room. FM-F asked staff if they were not in the facility if they would have called the family. FM-F stated the findings from the emergency room was dehydration with no improvement in kidney function. Was then transferred to another hospital with talks of starting dialysis, creatinine levels rose to 5.5.

Review of policy titled Pain-Clinical Protocol reads: monitoring, the staff will reassess the individuals pain and related consequences at regular intervals; at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. For example, review frequency and intensity of pain, ability to perform ADL's, sleep pattern, mood, and behavior. If a resident pain is complex or not responding to standard interventions, the attending physician may consider a psychiatric evaluation or referral to a pain clinic or specialist.

Policy review titled: Pain Assessment and Management under general guidelines, Conduct a comprehensive pain assessment upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. Assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain at least weekly in stable chronic pain. For monitoring and modifying approaches: If pain has not been adequately controlled, the multidisciplinary tram, including the physician, shall reconsider approaches and make adjustments as indicated.

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess falls to determine possible causative factors in order to develop resident centered interventions to minimize the risk of further falls for 1 of 3 residents (R48) who had a history of frequent falls. R48 sustained harm when he sustained lacerations to forehead and nose requiring sutures, an open fracture of the nasal bone, fracture of the fifth cervical vertebra, and multiple skin tears as a result of a fall 11/22/17. Findings include: R48 was observed on 12/11/17, at 5:38 p.m. wheeling himself in a wheelchair down a hallway on his unit, with rooke boots on both feet and a cervical collar in place around his neck. R48's diagnosis found on the admission Resident Face Sheet dated 8/1/17, indicated the resident had a recurrent dislocation, left hip, history of falling, hallucinations, unspecified and restlessness and agitation. R48's admission fall risk assessment dated	F 689	F689-Free of Accident Hazard/Supervision/Devices SPECIFIC RESIDENTS: Resident R48 affected by alleged deficient practice. A fall risk assessment was completed and care plan has been updated. OTHER RESIDENTS: All falls within facility will be reviewed at daily IDT, cause of fall will be determined, and care plan will be updated to reflect findings and interventions identified. Education will be given on January 22, to all KLC associates and a skills fair for all licensed associates on January 30 2018 and to all licensed staff. MONITOR: The Director of Nursing or designee will complete 1 random audit on fall IDT reports weekly for four weeks and then one random audit for two months. Results will be provided to Quality Council.	1/24/18

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8/1/17 was reviewed and found to be blank.

R48's fall risk assessment completed 9/1/17 indicated R48 was at high risk for falls.

A Care Area Assessment (CAA) dated 8/9/17, identified R48 to be at risk for falls r/t to weakness from recent hospitalization and impaired mobility following recurrent hip dislocations. The CAA further indicated staff were to keep the resident's call light easily assessible and assist as the resident as needed,and indicated the resident was to "work with therapy for strengthening. Staff will monitor for attempts to self-transfer. Notify medical doctor of changes. Proceed with plan of care."

R48's care plan last revised on 12/13/17, indicated the resident was at risk for falling related to history of falls and dependency upon staff for assist with transfers and ambulation. Approaches for care included: Pharmacy review of medications (initiated 12/13/17), hospice consult/admit related to resident needing extra care/attention (initiated 11/26/17), resident moved to room closer to the nurses' station (initiated 10/29/17), give verbal reminders not to transfer without assistance (initiated 10/23/17), hourly checks (initiated 8/29/17), two "stop and wait for assistance/use call light" signs were placed in resident's room (initiated 11/14/17), keep bed in lowest position with brakes locked, keep call light easily accessible, keep personal items and frequently used items easily accessible, provide environment free of clutter, provide proper, well maintained footwear (all initiated on 8/25/17).

R48 did not have a fall care plan developed until 8/25/17, after R48 had fallen in the facility, even

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though R48 had been admitted for a recurrent dislocation of the left hip, had a history of falling and the CAA from 8/9/17 had indicated for staff to proceed with care plan.

Review of progress notes from August 2017 through December 2017, indicated R48 had continued self-transferring attempts when in his room.

Review of fall incident reports from August 2017 through December 2017 included the following:

A fall on 8/25/17, at 1:15 a.m. occurred in R48's room. R48 had self-transferred and was found lying on his right side at the foot of his bed. R48 had used his urinal, and then was unable to state why he was getting up. R48's right elbow was visibly bleeding, and he was assisted to turn on his back. The report indicated R48 had complained of right ankle pain, right elbow pain and bilateral hip pain. R48 was sent to the emergency room for evaluation. R48 sustained a 6 centimeter (cm) by 5 cm skin tear to the right elbow. Fall intervention implemented: Resident was re-educated to use call light for assistance and two "stop and wait for assistance signs" were placed in his room. R48's medical record lacked documentation of a root cause analysis or an interdisciplinary team meeting review of this fall.

An incident report for a fall on 8/26/17, at 2:00 a.m. indicated the fall had occurred in R48's room. The report indicated R48 had slid out of his recliner, with no new injuries noted and at the time, R48 had stated he was ready to get up. A fall intervention implemented following this fall included every one-hour checks. R48's medical record lacked documentation of a root cause

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analysis or interdisciplinary team meeting review of the fall.

A fall incident report also indicated R48 had fallen on 9/20/17 at 5:40 a.m. in his room. R48 was found lying on the floor, on his back. When asked what he was doing R48 had stated, "I was getting up to get a quilt for my legs, they were cold." The report indicated R48 had been yelling and that is what had alerted the nursing assistant to his room. R48 had no new injury. R48's medical record lacked documentation of a root cause analysis or an interdisciplinary team meeting review of this fall. No new fall interventions were implemented.

A fall incident for 10/17/17, at 3:14 a.m. indicated the resident had fallen in his room. The report indicated R48 was heard yelling out for help from his room although he did not have his call light on. R48 was found lying on the floor at the foot of the bed, on his right side. R48 did not have his gripper socks on, his feet were wrapped in ace bandages and he had removed his Rooke boots. When R48 was asked what he was doing before he ended up on the floor, r R48 stated he was standing and bending over to work his bed control remote at the foot of his bed as he was about to get back into bed. The report notes indicated R48 sustained a 2 centimeter (cm) by 1 cm skin tear on the right elbow, which was bleeding moderately. R48 was reminded to use the call light. R48's medical record lacked documentation of a root cause analysis or an interdisciplinary team meeting review of this fall. No new fall interventions were implemented.

A fall on 10/27/17, at 7:40 a.m. occurred in R48's room. R48 was found sitting on floor at the side of

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his bed on the floor. The notes indicated R48 had stated he needed to "get out of here to go to work in the grain bin." R48 was assisted back to bed with a Hoyer lift (mechanical lift device) back to bed. The report indicated R48 had suffered no apparent injury, had no complaints of pain, and his vital signs were stable. The call light was secured on his chest with a clip following the fall, and R48 was instructed to call if he needed help, and to stay in bed. New fall intervention implemented included R48 being moved to a room closer to the nurses' station. R48's medical record lacked documentation of a root cause analysis or an interdisciplinary team meeting review of this fall.

A fall on 11/22/17, at 4:30 a.m. occurred in R48's bathroom. R48 was found on the floor in the bathroom lying on his stomach. R48 had a cut his forehead that was bleeding and his nose was bleeding. The notes indicated pressure was applied to areas with a wet cool cloth and passive range of motion was done. R48 was able to move all extremities freely with no complaints of pain. However, documentation indicated R48 was moaning from the injury to the head so an order was received to send R48 to the emergency department by ambulance. The report indicated R48's bed was in the low position and he had gripper socks on at the time of the fall. R48 sustained serious injuries including lacerations to forehead and nose, open fracture of nasal bone, fracture of the fifth cervical vertebra, and multiple skin tears. R48 required 3 stitches. Following the fall, the new fall intervention implemented was to initiate hospice services. R48's medical record lacked documentation of a root cause analysis or an interdisciplinary team meeting review of this fall.

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A fall on 12/13/17, at 11:45 p.m. occurred in R48's room. R48 was found with his knees on the floor and his arms on the bed nearest the window. When asked what R48 was doing he replied, "Well, getting the hay." R48 sustained a small 1 cm by 1 cm abrasion on his right knee. The report indicated R48 had gripper socks on at the time of his fall, and the bed was in the lowest position. The fall intervention implemented post fall included: medication review completed by the pharmacist. R48's medical record lacked documentation of a root cause analysis or an interdisciplinary team meeting review of this fall.

During an interview on 12/13/17, at 2:06 p.m. the director of nursing (DON) stated they do not complete a root cause analysis of each fall unless there is a significant injury that would require medical follow-up for the fall. The DON stated each fall was reviewed at an interdisciplinary team (IDT) meeting, held every morning at 8:30 a.m. Monday through Friday. The DON stated the fall incident was on a report sheet and the staff working at the time of the fall identified interventions, and the IDT team could add more interventions later. The DON stated meeting minutes were not recorded during the IDT team meetings. The DON stated R48 was a frequent faller, an impulsive resident that did not use the call light, and the DON added, "we have gotten rid of all of the alarms."

During an interview on 12/14/17, at 12:09 p.m. registered nurse (RN)-A stated a falls risk assessment was not completed for R48 upon admission. RN-A verified the falls risk assessment in the computer dated 8/1/17 was blank and R48's fall care plan was not initiated

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until 8/25/17. RN-A stated upon admission a fall risk assessment should have been completed for R48 and that would have determined the need for a care plan and interventions to be developed.

During an interview on 12/14/17, at 12:53 p.m. nursing assistant (NA)-A stated, "the only behavior I am aware of is he self-transfers, we try to make sure he is where he wants to be so he does not self-transfer." NA-A was not aware of any set time that staff should be checking on R48, and stated, "I check on him every two hours and I do peek in his room whenever I walk by, as he does like to self-transfer."

During an interview on 12/14/17, at 1:05 p.m. nursing assistant (NA)-B stated R48 was on one hour checks and the checks are documented in the computer system.

During an interview on 12/15/17, at 10:48 a.m. registered nurse (RN)-A stated hospice was implemented as a fall intervention to have a better sense to get R48 more comfortable and to help R48 be less anxious and restless during the night. RN-A stated R48 would get extra care with hospice services in place and they would review his medications. RN-A verified 6 of R48's falls, including the fall on 11/22/17, occurred during the night shift when extra care from hospice would not be occurring. RN-A verified no new fall interventions had been put into place for the night shift since the hourly checks were implemented for R48 on 8/28/17. RN-A verified the facility did not increase safety checks at night after the 11/22/17 fall when R48 sustained significant injury.

During an interview on 12/15/17, at 11:27 a.m. the

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F 689	Continued From page 33 DON verified R48 was at high risk for falls upon admission. The DON stated R48 had surgery for a hip dislocation prior to admission to the facility and had a history of falls. She also stated the falls risk assessment should have been completed upon admission to the facility and a falls care plan should have been implemented. A Fall Risk Management-Accident Prevention undated policy included, "Fall risk assessment, identification and implementation of appropriate interventions is necessary to reduce the risk of significant injury for those we serve."	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		1/24/18

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F 690	Continued From page 34 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess bladder continence and implement interventions to improve toileting ability and urinary and bowel incontinence for 1 of 1 resident (R61), reviewed for bladder and bowel incontinence. Findings include: R61's admission Minimum Data Set (MDS) dated 11/23/17, identified R 61 required for toilet use and transfers total dependence (full staff performance every time) and for urinary and bowel continence was frequently incontinent. R61's CAA (care area assessment) Summary Report, assessment dated 11/23/17, included urinary incontinence - at risk for urinary tract infection related to urinary incontinence. Staff to keep call light easily accessible and assist as needed. Staff will administer medications as directed by MD (medical doctor). Staff will monitor for changes in urinary habits and urine characteristics. Notify MD of changes. Proceed	F 690	F690-Bowel/Bladder Incontinence Catheter, UTI SPECIFIC RESIDENTS: Resident R61 affected by alleged deficient practice. A new 3 day bowel and bladder was issued and assessment will be completed with findings. Care plan will be updated accordingly. OTHER RESIDENTS: All admissions in the facility will have a 3 day comprehensive bowel and bladder assessment completed. Toileting program and care plan will be updated upon findings of 3 day comprehensive assessment.Education will be given on January 22, to all KLC associates and a skills fair for all licensed associates on January 30 2018 and to all licensed staff. MONITOR: The Director of Nursing or designee will pull a random of 3 audits weekly for the first four weeks and one random audit monthly for the next two months and report findings to Quality Council.	

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with plan of care. ADL (activities of daily living) Functional Status - at risk for ADL decline related to weakness from recent hospitalization and impaired mobility following hydrocephalus. Staff will encourage resident to participate as much as possible with ADL's. Staff will keep call light easily accessible and assist PRN. Staff will monitor for changes in ADL assistance needs. Resident will work with therapy for strengthening. Notify MD of changes. Proceed with plan of care.

During interview on 12/12/17, at 12:39 p.m. family member (FM)-D stated was not sure if staff were offering the toilet to R61. FM-D stated R61 could feel the urge sometimes as R61 tells me she has to go. R61 at the time nodded head yes in response to the question can she feel the urge to go to the bathroom.

On 12/14/17, at 7:16 a.m., R61 was observed to dressed and seated in wheelchair in room. At the time, R61 stated yes I can feel when I have to go to the bathroom. When asked if staff offer the toilet to her, R61 replied no. When asked if staff had offered the toilet or bedpan this morning when staff had assisted her with dressing and getting up, R61 stated no.

R61's care plan included last Reviewed/Revised: 11/22/17, ADL Functional / Rehabilitation Potential Problem: Toileting/Continence: Resident is limited in ability to toilet self related to hydrocephalus and weakness. R61 is incontinent. Approaches included assist with incontinence care if incontinent. Inspect condition of perineal area after each incontinent episode. Report any redness, rash, or broken area. Use barrier cream as needed. Provide extensive assistance for toileting. Wears depends (incontinent product).

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Physical and Occupational therapy for strengthening, ADL training. Revision of care plan on 12/13/17 included via Hoyer (mechanical lift) and two assist.

R61's Bladder Output and Training Record dated 11/17/17, 11/18/17, and 11/19/17, identified bladder and bowel each day, hourly times for each day, initials for each shift daily, and to document Bladder and Bowel. Documentation by staff identified R61 was incontinent, continent and dry for bladder and dry or type of stool consistency for bowel.

R61's Bladder Assessment dated completed 11/22/17, identified always incontinent (no episodes of continent voiding), monitor resident for risk factors for urinary incontinence - impaired mobility, dependent transfer (two person assist) and severe cognitive impairment. R61 was identified with mixed incontinence. Urinary toileting program identified R61 was not appropriate for toileting or retraining program, however no rationale for this conclusion was provided. Additionally, the bladder assessment summary was incomplete.

R61's bowel assessment dated completed 11/24/17, identified frequently incontinent, intraparenchymal hemorrhage with seizures, antipsychotics/antidepressants, NSAIDS, passive incontinence. Does not recognize appropriate time/place to defecate, or feel the urge/sensation for bowel movement. The bowel assessment summary was incomplete.

R61's record lacked a comprehensive analysis for bladder and bowel function.

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During interview on 12/13/17, at 2:06 p.m., registered nurse (RN)-B verified R61's record lacked an analysis for bladder function. At the time assistant director of nursing (ADON) and RN-B verified point of care (POC/computer charting system) and the Bladder Output and training Record sheet did not have information for staff to document if toilet/commode or bed pan were used during toileting. RN-B stated data was obtained from the nursing assistants,as R61 was unable to reliably indicate the information. At 2:32 p.m., RN-B verified R61's care plan lacked to indicate if R61 should be toileted and how often staff were to offer toilet/check and change incontinent product for R61.

During interview on 12/13/17, at 2:49 p.m., nursing assistant (NA)-C stated staff checked R61's brief every couple of hours because she cannot get up and use the toilet.

During interview on 12/13/17, at 2:55 p.m., RN-H stated R61 was checked and changed every two hours.

During interview on 12/14/17, at 8:02 a.m., the director of nursing (DON) stated she would expect a full bowel and bladder assessment be completed. The DON stated she would expect staff communicate with R61 and identify how R61 went, what patterns were and adjust the care plan accordingly. .

The facility policy Comprehensive Assessments, dated effective 11/28/16, indicated Purpose: to provide a comprehensive person-centered interdisciplinary care assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest

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F 690	Continued From page 38 practicable physical, mental and psychological functioning possible, a facility must make a comprehensive assessment of a resident's needs. Policy: 2. The assessment must accurately reflect the resident's status ... 7. Assessment process must include direct observation and communication with resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This includes nursing assistants assigned to the resident and culinary staff. 8. Residents and resident representatives will be involved in the comprehensive person-centered care planning. If participation of resident and representative in development of plan not practicable, explanation must be documented in the resident's medical record.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		1/24/18

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F 692	Continued From page 39 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to assess and reassess residents needs related to care plan interventions, monitor the effectiveness and coordinate care among an interdisciplinary team for 1 of 1 resident (R17) who had weight loss and poor nutritional status. Findings include: R17's care plan was not revised to address ongoing weight loss. The minimum data set (MDS) dated 9/29/17, indicated R17 was independent with eating and weighted 140 pounds, with a weight loss not prescribed by a physician. The monthly weight log identified a weight of 124.6 pounds for 12/17. This was a loss of 15.4 pounds in 3 months. R17's care plan for nutritional status edited 10/3/17, identified a goal to maintain her current ability. Interventions included to monitor/record weight monthly. The care plan also directed staff to provide high protein/high carbohydrate foods/fluids. In addition R17 was to have 8 oz of greek yogurt twice daily between meals, protein rich foods at all meals and arginard (supplement suitable for people who require a calorie restriction, and require additional supplements to promote wound healing)1 package po (by mouth) twice daily for wound healing. There was no revision of interventions or goals to address R17's weight loss. The current physician order report signed by the	F 692	F692-Nutrition/Hydration Status Maintenance SPECIFIC RESIDENTS: Resident R17 affected by alleged deficient practice. Care plan was updated on December 26, 2017 weekly review will be implemented for assured effectiveness. OTHER RESIDENTS: All residents that have significant weight loss will be reviewed weekly at IDT. Unit managers will review weights identified by IDT and list interventions in the care plans. Care plans will be monitored for the effectiveness of interventions. Education will be given on January 22, to all KLC associates and a skills fair for all licensed associates on January 30 2018 and to all licensed staff. MONITOR: The Director of Nursing or designee will run a weekly log of weights and audit all care plans with noted significant weight loss to ensure proper interventions. Then additionally one weight log monthly for two months.	

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provider, dated 10/19/17, read yogurt and arginard for wound healing. There were no physician orders related to weight loss. Review of physician progress notes from 4/19/17, to 12/7/17, revealed no assessment or interventions related to R17's continued weight lost.

R17's Nutrition Data formidentified a goal weight of 155-165 pounds. The assessment date of 3-24-17, identified a weight of 146.6 pounds or a decline of 11.69% in 30 days, 11.79% in 90 days, and 10.39% in 180 days. The assessment for 6/15/17, revealed a weight of 136 pounds for a decline of 15% in 90 days, and 18% in 180 days. An assessment dated 6/29/17, identified R17's weight was 138.4 pounds for a loss of 7.23% in 90 days and 18.17% in 180 days.

Additional monthly weights on the weight log were identified to be 1/17, 164 pounds, 2/17, 166 pounds, 3/17, 159.6 and 146.6 pounds, 4/17, 147 pounds, 5/17, 137.4 pounds, 6/17, 136 pounds, 7/17, 138.4 pounds, 8/17, 137.8 pounds, 9/17, 135 pounds, 10/17, 130.8 pounds, 11/17, 133.6 pounds, and 12/17, 124.6 pounds.

An untitled document provided by the facility for updating the physician dated 11/24/17, indicated for R17 a problem of weight loss 9/21/17, 140 pounds, 11/23/17, 125 pounds, next weight 11/30/17. There was no evidence the physician addressed the 15 pound weight loss. A progress note dated 11/26/17, noted on 9/21/17, weight was 140 pounds and 11/23/17, weight was red flagged due to a decline to 125 pounds. The nurse practitioner was notified. The next weight was due on 11/30/17.

A note dated 12/12/17, was the first dietary note

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F 692	Continued From page 41 to address R17's significant weight loss. Current weight was 124.6 pounds and height of 63 inches. The note identified R17 needed 1425-1710 calories/day, 68-85 grams of protein/day, and 1400-1700 milliliters of fluid/day. The note identified yogurt twice a day for extra calories/protein and arginade. Would recommend discontinue use of arginade and start of glucerna twice a day. On 12/14/17, at 12:05 p.m. the culinary director stated the dietitian placed notes in progress notes and if there was a concern would address with interdisciplinary team. Suggestions were made and passed on to the unit coordinator; and updates of the care plan were completed. On 12/15/17, at 9:38 a.m. RN-A stated no additional information related to R17's weight loss had been located. RN-A stated the facility will have the nurse practitioner (NP) review and assess R17 today. On 12/15/17, at 10:07a.m., the director of nursing (DON) stated dietary reviews weight loss weekly and addresses with physician. Physician reviews for expected weight loss and will change things if needed. The DON stated documentation should be in the building to review so facility staff to could put interventions in place to prevent further weight loss. The DON stated the physician should have been notified. At 1:58p.m. the DON stated she believed the nutritional data sheet was filled out by the dietitian. The DON stated her expectation would have been to review interventions and revise if needed due to continued weight loss and last up date in 6/17.	F 692		
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		1/24/18

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F 758 SS=D	Continued From page 42 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 43 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete an analysis of sleep and provide physician justification for the increased use of an antidepressant medication prescribed for a diagnosis of insomnia for 1 of 5 residents (R45) reviewed for unnecessary medications. Findings include: R45's admission Minimum Data Set (MDS) dated 11/15/17, identified R45 had a diagnosis of Alzheimer's disease, was cognitively intact and had no trouble falling asleep, staying asleep or sleeping too much. On 12/13/17, at 12:46 p.m., R45 was observed to be sitting in her room in a wheelchair lifting her legs up and down while watching T.V. At 2:57 p.m., R45 was sitting in a recliner in her room watching T.V. On 12/14/17, at 7:16 a.m., R45 was observed to be in bed sleeping. R45's care plan, last revised date 11/10/17, indicated Psychotropic Drug Use Problem:	F 758	F758-Free from Unnec Psychotropic Meds/PRN SPECIFIC RESIDENTS: Resident R45 affected by alleged deficient practice. Resident has discharged from the facility. OTHER RESIDENTS: Any resident that has a medication related to insomnia or complaint of sleep disturbance will require a 3 day sleep log and sleep assessment. With any PRN psychotropic a sleep log will be scheduled to be completed by day 14 for justification of use by a physician before day 14. Education will be given on January 22, to all KLC associates and a skills fair for all licensed associates on January 30 2018 and to all licensed staff. MONITOR: The Director of Nursing or designee will review all PRN antipsychotic medications for reassessment on day 10 to ensure justification of discontinue or schedule medications.	

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Resident receives antidepressant/antipsychotic medication related to diagnoses of depression, insomnia and psychosis. Approaches included monitor for change in resident's functional status as needed, monitor orthostatic vital signs monthly, monitor resident's mood and response to medication, pharmacy consultant review per facility policy and psychotropic med monitoring: monitor for target behaviors (makes negative statements, isolates self, sadness, withdrawn, difficulty coping, feeling helpless, hallucinations, delusions, paranoid statements). Chart when observed and notify medical doctor. Problem last revised 12/13/17: resident experiences insomnia/change in usual sleep pattern. Approaches included administer medications as ordered. Monitor and record effectiveness. Monitor and report any adverse side effects. Assess resident for presence/absence of sleep apnea. Discourage daytime napping. Encourage limiting caffeine intake after seven p.m. Provide comfortable environment to promote sleep (e.g., clean bedding, comfortable bed clothing, incontinence care, comfortable temperature, ventilation). Reduce environmental disruptions (e.g., noise, staff disruptions, light).

R45's current physician orders identified an order dated 11/28/17, for Trazadone (antidepressant) 100 mg at bedtime for insomnia, which had been increased from admission orders of Trazodone 100 mg at bedtime as needed (PRN).

R45's sleep study upon admission dated 11/8/17 (start time of 5:00 p.m.), 11/9/17, 11/10/17 and 11/11/17 (end time of 5 p.m.), identified R45 was sleeping seven to nine hours every night.

R45's medication administration record dated for

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the month of 11/17, identified Trazodone 100 mg at bedtime PRN (start date 11/8/17, with end date 11/28/17) was administered on 11/10/17, at 8:48 p.m., 11/15/17, at 8:21 p.m., 11/16/17, at 10:00 p.m., 11/17/17, at 1:36 a.m., 11/20/17, at 12:26 a.m. and 11/23/17, at 11:45 p.m.

R45's progress notes dated 11/8/17, through 11/28/17, included the following:
11/13/17: reported has been sleeping well and if having trouble aware needs to request PRN Trazodone.
11/17/17: 2:11 a.m. complained of not falling asleep, administered Trazodone PRN, room is dark and T.V. is off.
11/20/17: 1:00 a.m. refused sleeping pill, then asked for it 40 minutes later. Upon returning to room was asleep. 12:58 a.m. requested Trazodone for sleep when pain meds given at 2100 (9:00 p.m.) was not working well.
11/27/17: sleeping well this shift, toileted around three a.m., no complaints.
11/28/17: doctor here on rounds. New orders to change Trazodone to scheduled.

R45's physician progress note dated 11/28/17, indicated resident has no specific concerns and neither do the nurses. Systems review included she states she is sleeping o.k.
Impression/Report/Plan identified for the problem of insomnia R45 took Trazodone regularly at home, so it was scheduled.

R45's record lacked a comprehensive sleep assessment and documentation to justify the increase in Trazodone for sleep.

On 12/14/17, at 12:33 p.m., licensed practical nurse (LPN)-B stated R45 had an order on

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F 758	Continued From page 46 admission for Trazodone 100 mg as needed and on 11/28/17, the Trazodone was changed to being scheduled every night. LPN-B stated on 11/28/17, R45 was seen by the physician and was assuming R45 complained of problems sleeping. When queried regarding if a sleep assessment was completed, LPN-B stated a sleep study was done on 11/11/17, and was not sure if the facility did a sleep assessment, but would ask someone. At 12:43 p.m., LPN-B stated the sleep study already completed was what the facility used. LPN-B stated the only sleep log completed was dated 11/8/17, through 11/11/17. On 12/15/17, at 10:18 a.m., the director of nursing (DON) stated a three day sleep log was completed and the sleep log was shown to the nurse practitioner. From there a decision is made if changes were needed or not. The DON stated the family was concerned R45 was not sleeping and the med change was one of the requests they had.	F 758		
F 922 SS=C	Procedures to Ensure Water Availability CFR(s): 483.90(i)(1) The facility must-- §483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish adequate policies and procedures for emergency water supply. Findings include: During the entrance conference on 12/11/17, at	F 922	F922-Procedures to Ensure Water Availability SPECIFIC RESIDENTS: All residents affected by the alleged deficient practice. OTHER RESIDENTS: Procedures to ensure water availability will be researched to determine what is missing	1/24/18

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F 922	Continued From page 47 1:26 p.m., information regarding the facility's emergency water source was requested. The following was provided: The facility's Emergency Water Agreement with signature date of 3/4/15, indicated in the event of an emergency (local disaster, flood, etc.) Owatonna Culligan agrees to supply the facility with bottled water under the following conditions: 1) Owatonna Culligan has fulfilled its primary obligation to its current, active customer base first. 2) Owatonna Culligan employees are available to provide safe distribution of products in the event of an emergency. 3) Owatonna Culligan has sufficient product to distribute. The agreement further indicated Owatonna Culligan does not guarantee that any or all products will be available during and after an emergency and they reserve the right to substitute products based on availability. The preferred package will be provided in five gallon bottles. Deliveries will be attempted within 24 hours from the initial call. We also understand that Owatonna Culligan reserves the right to determine any and all distribution decisions. Owatonna Culligan recommends that all health facilities keep an adequate supply of bottled water on hand at all times. This agreement will be valid until 3/1/16. Attached to the agreement was an email dated 12/11/17, addressed to the facility administrator, which read we are extending the emergency water agreement, our water is potable and can be used for potable and non-potable purposes. Our general manager has approved this to be extended for another two years. In addition, the administrator provided a Memo dated 10/23/17, which indicated Notes from emergency planning meeting with Fire Chief on	F 922	from our water policy and the policy will be re-written to include all requirements including the defined source of water when there is a loss of normal water supply, provisions for storing the water, both potable and non-potable, and a method for distributing the water, and a method for estimating the volume of water required. After the policy is rewritten, staff members will be educated on the revised policy by January 22nd, 2018	

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 _____	12/15/2017

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 922	Continued From page 48 10/23/17, emergency operations center (EOC) will supply potable water and other emergency supplies, primarily medical, if needed. The facility lacked a written procedure, which defined the source of water when there is a loss of normal water supply, including provisions for storing the water, both potable and nonpotable, a method for distributing the water and a method for estimating the volume of water required. During interview on 12/15/17, at 9:17 a.m., the administrator stated the process has been the same for several years. The process had been expanded after talking to the Owatonna fire chief. The fire department will provide any water needed. The administrator indicated as per the Owatonna Culligan water agreement, the water was stored in five gallon bottles. The administrator stated the EOC was for big emergency back up to Culligan as Culligan was the first supplier. When asked about a written procedure for the method of distributing the water and a method for estimating the volume of water required, the administrator stated the information was not written into the policy, but the facility determined 2.5 gallons of water per resident per day were needed.	F 922		

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	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**12/13/2017**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this 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) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/11/2018

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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	245426	A. BUILDING **02 - KODA LIVING COMMUNITY** B. WING _____	**12/13/2017**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. KODA Living Community is a 1-story building with no basement. The original building was constructed in 2013 and was determined to be of Type V (111) construction. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection in the corridors, spaces open to the corridors, and all residents sleep rooms that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 77 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting	K 291		2/1/18

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K 291	Continued From page 2 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 observation and interview, the Facility failed to maintain emergency lighting in accordance with 7.9. The deficient practice could affect 77 out of 77 residents. 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 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/13/17, during documentation review, documentation could not be located to show that the battery powered emergency lights were being tested 30 seconds monthly and ran for 90 minutes annually. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	K291 – E Emergency Lighting (documentation) This has been corrected with new a documentation book suggested during the inspection. The book will have tabs for each item that needs to tested or inspected at regular intervals. There are two emergency lights located at generator and rear entrance door that leads to the generator. They will be tested monthly, and recorded in the log book.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and	K 321		2/1/18

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K 321	Continued From page 3 doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain hazardous areas are protected by a fire barrier having 1-hour fire resistance rating. This deficiency could effect 77 of the 77 residents. Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be	K 321	K321 – F Hazardous Areas – Enclosure (tiny hole in O2 room door – manufacture error) This has been correct with fire caulking and metal plate patch per the manufacturer's recommendation.	

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K 321	Continued From page 4 self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/13/2017, observation revealed a hole in the door of the oxygen storage room. This penetration went completely thorough the door. This deficient practice was verified by the Facility Maintenance Director.	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345		2/1/18

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K 345	Continued From page 5 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. This deficient practice could effect 77 of 77 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/13/2017, during documentation review, documentation could not be located to show that the smoke detector sensitivity inspection had occurred with the last 2 years. This deficient practice was verified by the Facility Maintenance Director.	K 345	K345 – F Fire Alarm System – Testing and Maintenance (documentation of smoke detector sensitivity) This was completed as required, but the documentation was misplaced at the time of the inspection. The new log book will help us keep all records required for the annual inspection in one location, ready for review as necessary.	

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K 521	Continued From page 6	K 521		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to ensure that the fire/smoke dampers were maintained according to 9.2 and in accordance with the manufacturer's specifications. The deficient practice could affect 77 out of 77 residents. HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/13/2017, documentation could not be provided that indicated the fire/smoke damper test had occurred within the past 4 years. This deficient practice was verified by the Facility Maintenance Director.	K 521	K521 – F HVAC (fire damper test needs to be completed every 4 yrs. – not done) The testing is scheduled to be completed by Owatonna Heating and Cooling by January 30th, 2018.	2/1/18

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K 918	Continued From page 7	K 918		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview,	K 918	K918 – F Electrical systems – Essential	2/1/18

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K 918	Continued From page 8 the Facility failed to provide complete written records of generator maintenance and testing. This deficient practice could affect 77 of 77 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918	Electric System (documentation on generator testing/inspection) The missing documentation was due to employee failure. Corrective action has been taken with employee. The monthly generator testing and the weekly inspection are back on schedule as required. A new documentation book with tabs in the correct order for the State annual inspection process will be used going forward. There is a tab for each item that needs periodic testing or inspection The Director of Environmental Services will audit the book periodically to insure that testing and inspection occur at the proper intervals, and is documented correctly.	

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K 918	Continued From page 9 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/13/2017, during documentation review, documentation could not be located to show that the weekly inspection on the emergency generator had occurred during the period of July 24, 2017 to December 1, 2017 and the emergency generator had not had a monthly load test during the months of August, September, and October, 2017. This deficient practice was verified by the Facility Maintenance Director.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of	K 920		2/1/18

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K 920	Continued From page 10 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 37 of the 77 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM	K 920	K920 – E Electrical Equipment (power strip found in resident room with frig / microwave plugged in) This has been corrected. Additionally, our staff members will be educated during the January all-staff meeting to monitor resident rooms for misuse and overuse of power strips.	

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 _____	**12/13/2017**

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 920	Continued From page 11 on 12/13/2017, a refrigerator and microwave in Resident Room 410 were observed plugged into a power strip. This deficient practice was verified by the Facility Maintenance Director.	K 920		