Electronically delivered
February 3, 2021

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

RE: CCN: 245426
Cycle Start Date: January 13, 2021

Dear Administrator:

On January 13, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by April 13, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 13, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	C 01/13/2021

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 COVID-19 Focused Infection Control survey was conducted on 1/11/21 through 1/13/21 , at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/11/21 to 1/13/21 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. In addition, a COVID-19 Focused Infection Control survey was conducted to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The following complaints were found to be unsubstantiated: H#5426043C H#5426044C H#5426045C H#5426047C H#5426048C H#5426049C However, as result of the investigation a deficiency was issued at F609 and F610 The following complaint was found to be	F 000		

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

Electronically Signed | 02/12/2021

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F 000	Continued From page 1 substantiated with no deficiencies cited due to action implemented by the facility prior to survey: H#5426046C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		2/23/21

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F 609	Continued From page 2 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse/neglect were reported to the State Agency (SA) timely, in accordance with established policies and procedures, for 1 of 1 resident (R1) reviewed for allegations of abuse. Findings include: Review of a vulnerable adult (VA) report submitted to the SA on 1/5/21, at 2:01 p.m. indicated R1 reported to a family member that a nursing assistant (NA) grabbed R1's left arm to reposition her and that it "hurt". R1 stated the incident occurred on 1/3/21, sometime before or after breakfast. The report indicated R1 requires staff assist to reposition her from side to side. R1 obtained 4 bruises (the size of fingertips) between R1's left shoulder and elbow. The family reported R1's concerns to facility staff on 1/6/21. Review of the facility incident/VA reports did not include a VA report had been completed/filed for R1. Interview on 1/12/21, at 1:00 p.m. licensed social worker (LSW)-A confirmed the above allegation of abuse, had not been reported to the SA. LSW-A indicated the administration staff did not	F 609	SPECIFIC RESIDENTS: Resident R1 affected by the alleged deficient practice remains with in the facility. On January 12th 2021 upon notification of possible abuse/neglect immediately a internal report and investigation was implemented. Allegations of Abuse/Neglect have been unsubstantiated by MDH. OTHER RESIDENTS: For all residents in the facility,all mandated facility reporters will insure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but not later than 2 hours after the allegation is made, if the event that causes the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials. All mandated reporters will review requirements and receive education on February 23, 2021. MONITOR: The Director of Nursing or	

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F 609	Continued From page 3 think the allegation was substantial, so a VA was not filed. LSW-A verified facility policy, directs staff to report allegations of abuse/neglect immediately to the SA, prior to investigation. Interview on 1/13/21, at 11:45 a.m. the DON confirmed a VA report for R1 had not been filed, because it was determined R1's bruises were caused by 2 intramuscular (IM) injections that were given. Although, the facility determined the bruises on R1's left arm were caused by IM injections, a thorough investigation had not been completed to rule out other possible factors. Review of the facility's policy Abuse Prevention Plan dated 10/20/19, directed the building charge, administrator, DON, LSW, or their designee to report suspected abuse, neglect, misappropriation of resident property and/or financial exploitation in accordance with legal requirements. The requirements includes contacting the SA immediately upon receiving the report of possible abuse.	F 609	Designee will audit all vulnerable adult reports for the first four weeks starting February 23, 2021 to assure proper time line of reporting is completed. Results will be provided to Quality Council for reassessment.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		2/23/21

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F 610	Continued From page 4 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 1 resident (R1) to rule out abuse, and determine if interventions were needed for residents to remain free from abuse. This had the potential to affect all residents residing in the facility. Findings include: Review of a vulnerable adult (VA) report submitted to the SA on 1/5/21, at 2:01 p.m. indicated R1 reported to a family member that a nursing assistant (NA) grabbed R1's left arm when repositioning her and that it "hurt". R1 stated the incident occurred on 1/3/21, sometime before or after breakfast. The report indicated R1 requires staff assist to reposition her from side to side. R1 obtained 4 bruises (the size of fingertips) between R1's left shoulder and elbow. The family reported R1's concerns to facility staff on 1/6/21. Review of the facility incident/VA reports did not include a VA report had been completed/filed for R1. Review of hand written notes by the director of nursing (DON) with no date or time, indicated R1 received a B12 intramuscular (IM) injection on 1/1/21, by facility staff. The notes indicated licensed practical nurse (LPN)-A pulled up R1's deltoid muscle to give the injection. R1 did not complain of pain and there was no bleeding or bruising at the time. The note further indicated	F 610	SPECIFIC RESIDENTS: Resident R1 affected by the alleged deficient practice remains within the facility. On January 12th 2021 immediately upon notification of possible abuse/neglect a investigation was implemented. Interviews of investigation included resident, caregivers, family, physician, and LTCGS. Allegations of Abuse/Neglect have been unsubstantiated by MHD. OTHER RESIDENTS: For all residents in the facility, all mandated facility reporters will insure all alleged violations involving abuse and neglect are reported immediately but not later than 2 hours after the allegation is made. Facility mandated reporters will complete a thorough investigation of allegations to rule out abuse and/or neglect and determine interventions are in place to assure all residents are to remain free from injury. All mandated reporters will review requirements and receive education on February 23, 2021. MONITOR: The Director of Nursing or Designee will audit all vulnerable adult reports for the first four weeks starting February 23, 2021 to assure thorough investigation and interventions are completed. Results will be provided to Quality Council for reassessment.	

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F 610	Continued From page 5	F 610		

when the DON asked R1 if the B12 and COVID-19 injections hurt her arm, R1 stated her arm was sore after she received them. The DON further asked R1 if she felt anyone hurt her while giving her the injections, R1 stated she did feel she was being hurt, other than her arm was sore. Review of informal typed notes by licensed social worker (LSW)-A, (no date or time) included an investigation started when registered nurse (RN)-A reported the allegation of abuse at 1:30 p.m. (no date). LSW-A indicated RN-A reported R1 had "hand print" bruising on the upper left arm. LSW-A stated she assessed R1's bruises that looked like a form of 4 "finger sized" spots to the upper left arm. The note indicated R1 had a history of bruising. LSW-A asked R1 if she felt in danger by staff , but the note did not include an answer to that question. There were only 2 out of 9 NA's interviewed that had worked with R1 surrounding the incident. NA-A who reported the bruising to RN-A, was also not interviewed nor was the contracted staff that gave the COVID-19 injection. The note included a final determination was confirmed by the DON, that the bruising on the left upper arm occurred from a B12 injection on 1/1/21, or possibly the COVID-19 injection on 12/30/19.

Although a partial investigation had been done, the staff had not completed an investigation that was thorough enough to determine and unsubstantiated the alleged allegation of abuse. There were no interventions implemented after the facility investigative findings, to prevent the incident from re-occurring.

Interview on 1/13/21, at 11:30 a.m., LSW-A, confirmed a thorough investigation had not been completed. LSW-A confirmed not all staff

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F 610	Continued From page 6 surrounding the incident were interviewed and the investigation was incomplete. The LSW stated since the allegation was determined unsubstantial within an hour after it was reported, she did not go further with a 5 day investigation. Interview on 1/13/21, at 11:45 a.m. the DON confirmed a VA report for R1 had not been filed, because it was determined R1's bruises were caused by 2 intramuscular (IM) injections. Although, the facility determined the bruises on R1's left arm were caused by IM injections, a thorough investigation had not been completed to rule out other possible factors. Review of the facility's policy Abuse Prevention Plan dated 10/20/19, directed the DON, LSW, or their designee to investigate all suspected abuse, neglect, misappropriation of resident property and/or financial exploitation. Measures will be taken to identify the source of the alleged abuse and prevent future incidents. Safety measures will be implemented, to ensure safety of the suspected VA and other residents. Within 5 working days, the DON, LSW, or their designees will submit the facilities investigative report to the SA.	F 610		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:	F 886		3/8/21

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F 886	Continued From page 7 §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the	F 886		

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F 886	Continued From page 8 transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain written COVID-19 test results from contracted staff, according to Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to prevent the spread of COVID-19. This had the potential to affect all residents residing in the facility as well as facility staff. Findings include: Review of the facility resident and staff COVID-19 testing schedule, indicated the facility had been testing their staff and residents twice weekly. Review of the facility county positive COVID-19 rates, identified rate ranges 7.1 to 16.8 percent (%) since 11/20 to 1/7/21 (considered medium to high activity rates). Review of the COVID-19 testing schedule and results for hospice contracted service staff, did not include documented testing to include dates/ results or that testing had been done. The current hospice schedule indicates there are 3 different	F 886	SPECIFIC RESIDENTS: Residents receiving hospice services affected by the alleged deficient practice remain within the facility. Residents have completed weekly testing according to the testing plan for the facility and have all received negative Covid-19 results. OTHER RESIDENTS: For all residents, receiving services from outside provider□s on a weekly basis, the facility will ensure to receive documentation of Covid-19 last testing date and results. The provider entering on a weekly basis will confirm testing at community COVID-19 activity level and/or outbreak status. Additionally, provider will have a copy of their last COVID-19 test date with negative results and staple to the facility provided entrance screening form. If testing timeline dose not fall within guidance, the provider will not be allowed to provide services or will complete a BinaxNOW test and staple the result to the facility entrance screening form.	

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F 886	Continued From page 9 hospice staff that make visits three times weekly. The hospice staff did not participate in COVID-19 testing at the facility. Interview with the facility infection preventionist (IPP) and the director of nursing (DON) on 1/13/21, at 10:00 a.m. confirmed the facility had not required contracted hospice staff to provide documentation for proof of COVID-19 testing that included dates and results. . Review of the facility COVID-19 Community Testing Plan dated 9/2//20, indicated the purpose of the plan is to identify COVID-19 positive residents and staff through viral testing: testing is a priority to help inform clinical care and infection prevention and control practices in our setting. The plan directed facility staff to conducted all testing in accordance with the Centers for Medicare and Medicaid Services (CMS regulatory guidelines/requirements. County activity level table: Low activity: less than 5% positive cases with minimum testing frequency of once a month Medium activity: 5% to 10% positive cases with minimum testing frequency of once a week High activity: greater than 10% positive cases with a minimum testing frequency of two times weekly.	F 886	MONITOR: The Director of Nursing or Designee will audit all providers entering the facility on a weekly bases. Provider screening forms and COVID-19 test results will be audited for four weeks starting March 8th 2021 to ensure accuracy of documentation of the last Covid-19 test preformed and results. Results will be provided to Quality Council for reassessment.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 3, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: B01W11

Dear Administrator:

The above facility was surveyed on January 11, 2021 through January 13, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00644	A. BUILDING: _____ B. WING _____	C 01/13/2021

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/11/21 to 1/13/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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

Electronically Signed | 02/12/21

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2 000	Continued From page 1 The following complaint(s) were found to be unsubstantiated: H#5426043C H#5426044C H#5426045C H#5426047C H#5426048C H#5426049C Although the above complaints were found to be unsubstantiated, associated deficiencies were issued at F609 and F610. Licensing order issued at MN State Statue 626.557 Subd. 3 The following complaint was found to be substantiated with no deficiencies issued, due to action taken by the facility prior to survey: H#5426046C Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	21980		2/23/21

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21980	Continued From page 3 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21980	CORRECTED	

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21980	Continued From page 4 facility failed to ensure allegations of abuse/neglect were reported to the State Agency (SA) timely, in accordance with established policies and procedures, for 1 of 1 resident (R1) reviewed for allegations of abuse. Findings include: Review of a vulnerable adult (VA) report submitted to the SA on 1/5/21, at 2:01 p.m. indicated R1 reported to a family member that a nursing assistant (NA) grabbed R1's left arm to reposition her and that it "hurt". R1 stated the incident occurred on 1/3/21, sometime before or after breakfast. The report indicated R1 requires staff assist to reposition her from side to side. R1 obtained 4 bruises (the size of fingertips) between R1's left shoulder and elbow. The family reported R1's concerns to facility staff on 1/6/21. Review of the facility incident/VA reports did not include a VA report had been completed/filed for R1. Interview on 1/12/21, at 1:00 p.m. licensed social worker (LSW)-A confirmed the above allegation of abuse, had not been reported to the SA. LSW-A indicated the administration staff did not think the allegation was substantial, so a VA was not filed. LSW-A verified facility policy, directs staff to report allegations of abuse/neglect immediately to the SA, prior to investigation. Interview on 1/13/21, at 11:45 a.m. the DON confirmed a VA report for R1 had not been filed, because it was determined R1's bruises were caused by 2 intramuscular (IM) injections that were given. Although, the facility determined the bruises on R1's left arm were caused by IM injections, a thorough investigation had not been completed to rule out other possible factors.	21980		

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21980	Continued From page 5 Review of the facility's policy Abuse Prevention Plan dated 10/20/19, directed the building charge, administrator, DON, LSW, or their designee to report suspected abuse, neglect, misappropriation of resident property and/or financial exploitation in accordance with legal requirements. The requirements includes contacting the SA immediately upon receiving the report of possible abuse. SUGGESTED METHOD FOR CORRECTION: The administrator or designee could educate staff on the vulnerable adult policy that includes the requirements of reporting abuse timely to the state agency. The administrator could conduct audits of allegations of abuse for timely reporting. The administrator could review audit findings with the quality assessment and assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		