



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 5, 2024

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

RE: CCN: 245426
Cycle Start Date: June 6, 2024

Dear Administrator:

On July 5, 2024, we notified you a remedy was imposed. On August 22, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 20, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 6, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 9, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 24, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 5, 2024

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

Re: Reinspection Results
Event ID: 05T212, PIT812, and W7LP12

Dear Administrator:

On July 24, 2024, August 1, 2024, and August 22, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed reinspections of your facility, to determine correction of orders found on the surveys completed on June 6, 2024, June 28, 2024, and July 24, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 5, 2024

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

RE: CCN: 245426
Cycle Start Date: June 6, 2024

Dear Administrator:

On June 26, 2024, we informed you that we may impose enforcement remedies.

On June 28, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 6, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 6, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 6, 2024.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 6, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Koda Living Community will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 6, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 6, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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

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

PRINTED: 07/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/26/24, 6/27/24, and 6/28/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H54265050C (MN00104320, MN00104382), with a deficiency cited at F657. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
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.	F 657			7/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/10/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page 1 (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 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 1 of 4 residents (R1) observed who were identified to have behavioral issues not addressed in the care plan. Findings include R1's Continuity of Care Document (CCD) dated 6/27/24, identified an admission date of 10/22/21. Medical diagnoses included anxiety disorder, dementia (deterioration of memory, language, and other thinking abilities), restless leg syndrome (overwhelming urge to move legs, usually associated with unpleasant sensations often during sleep and relieved by movement), pain, arthritis (condition that affects the joints causing pain, stiffness, and reduced movement), abnormalities of gait and mobility, history of falling, and weakness. R1's Behavior Observation assessment (annual)	F 657	- Comprehensive care plan for R1 updated to include individualized behaviors. - All residents with history of behaviors will be reviewed to ensure comprehensive care plans include resident's behavior symptoms and individualized interventions. - All clinical managers and social services associates received re-education on Comprehensive Assessments and Care Planning Policy (NS101); specifically related to dementia, cognition, and behaviors. - Review of care plans will be completed weekly for 6 weeks for residents who have had active behaviors to ensure care plan has been updated		

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

PRINTED: 07/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page 2 dated 3/20/24, identified a section titled 'Other behavior symptoms not directed toward others' and to note presence of symptoms and frequency. The assessment indicated R1's behaviors included disrobing in public and the behavior occurred one to three days in the last seven days. The assessment identified that this behavior intruded on the privacy and activity of others and remained unchanged from prior assessments. Action taken to continue current plan of care. R1's Minimum Data Set (MDS) Quarterly review dated 3/20/2024, identified severe cognitive impairment. MDS failed to identify R1 wandered (moves with no rational purpose, seemingly oblivious to needs or safety). R1 was independent with transfers and wheelchair use. R1's care plan edited on 3/20/24, identified R1 exhibited wandering and wandered to other units and front door. R1 wandered into other resident rooms and had a history of using the bathroom in inappropriate places. Interventions included R1 to have supervision when ambulating off the unit, redirection when wandering in others rooms, attempt to redirect back to unit if R1 walked off unit. Although the Behavior Observation Assessment dated 3/20/24, identified R1 demonstrated disrobing in public behaviors the care plan was not revised to include the behavior(s). A facility reported incident (FRI) submitted to the State Agency (SA on 6/22/24 included staff noticed R1 in a male residents room with door was closed. Staff found R1 standing next to her wheelchair with her pants and brief down and	F 657	with approaches and interventions. Audits will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.		

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

PRINTED: 07/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024	
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page 3 near her knees. R1's care plan was not revised after the incident to include the behavior of disrobing until 6/27/24. R1's care plan was revised on 6/27/24, to include that R1 would occasionally remove clothing at inappropriate times and in appropriate places. No goal or interventions to manage the behavior were included. During an interview on 6/26/24 at 12:27 p.m., nursing assistant (NA)-A stated R1 did not always understand what staff say to her. She wandered frequently and went into other resident rooms and laid in their beds. NA-A stated R1 had been in seven or eight rooms that morning. "with R1 it is a thing for her to strip naked and walk the halls." During an interview on 6/26/24 at 1:18 p.m., NA-B stated R1 "liked to strip and walk down the hall, it was mainly bottoms down, but not the top, she did it a lot". NA-B stated there was no direction given on how to divert or stop it from happening. "Nothing has been put in the care plan for us and no one had directly told us anything about that. Miscommunication happens a lot". During an interview on 6/26/24 at 1:43 p.m., licensed practical nurse (LPN)-A stated R1 strips bottom half down anytime of the day. R1 typically would strip in her room and then go into the hallway. During an interview on 6/26/24 at 3:19 p.m., NA-D stated R1 strips her bottom half down most commonly in her room and then goes in the hallway. NA-D stated that one time she found her in the kitchen "stripped."			F 657			

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

PRINTED: 07/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page 4 During an interview on 6/26/24 at 3:26 p.m., NA-E stated that he has always seen R1 have her clothes off in her room and he would go in and redress her. NA-E stated that there was no direction given on how to proceed if R1 was unclothed in the hall. During an interview on 6/27/24 at 2:04 p.m., clinical manager (CM)-A stated unfortunately R1 did have a history of taking her clothes off anywhere, and frequently removed them. Recently she took them off at the dining room table. R1's family was aware of it, and they have brought in different textures of clothes and CM-A indicated she did not think that the texture or the size of the clothing was a factor in R1 removing her clothes. CM-A recommended redirection, aiding, and to keep R1 in eyesight as able to prevent the behavior. CM-A was not aware if the care plan had interventions in place for R1 disrobing. During an interview on 6/28/24 at 10:15 a.m., with Regional Director of Clinical Services-South Region (RDSCS), Director of Nursing (DON) and Administrator were present. DON stated there was not a specific assessment for wandering in rooms and undressing. DON explained it was common for R1 to wander due to her cognition level and her care was updated on 6/27/24 to include removal of clothing at inappropriate times and places. DON stated assessments were completed, and care plans created so staff have appropriate interventions to maintain safety and continuity of care. The facilities Comprehensive Assessments and Care Planning policy revision dated 9/27/23, identified that to provide a comprehensive	F 657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 657	Continued From page 5 person-centered interdisciplinary care assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental and psychological functioning possible, a facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. 7. a facility should use the results of the assessment to develop, review and revise the resident's person-centered comprehensive care plan. 8. 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 assistant assigned to the resident and culinary staff.	F 657			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 5, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: PIT811

Dear Administrator:

The above facility was surveyed on June 26, 2024 through June 28, 2024 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00644	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
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 6/26/24, 6/27/24 and 6/28/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

07/10/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00644	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54265050C (MN00104320, MN00104382) with a licensing order issued at 0570. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be 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	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00644	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From page 2 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			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan for 1 of 4 residents (R1) observed who were identified to have behavioral issues not addressed in the care plan. Findings include R1's Continuity of Care Document (CCD) dated 6/27/24, identified an admission date of 10/22/21. Medical diagnoses included anxiety disorder, dementia (deterioration of memory, language,	2 570	Corrected	7/30/24	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00644	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 570	Continued From page 3 and other thinking abilities), restless leg syndrome (overwhelming urge to move legs, usually associated with unpleasant sensations often during sleep and relieved by movement), pain, arthritis (condition that affects the joints causing pain, stiffness, and reduced movement), abnormalities of gait and mobility, history of falling, and weakness. R1's Behavior Observation assessment (annual) dated 3/20/24, identified a section titled 'Other behavior symptoms not directed toward others' and to note presence of symptoms and frequency. The assessment indicated R1's behaviors included disrobing in public and the behavior occurred one to three days in the last seven days. The assessment identified that this behavior intruded on the privacy and activity of others and remained unchanged from prior assessments. Action taken to continue current plan of care. R1's Minimum Data Set (MDS) Quarterly review dated 3/20/2024, identified severe cognitive impairment. MDS failed to identify R1 wandered (moves with no rational purpose, seemingly oblivious to needs or safety). R1 was independent with transfers and wheelchair use. R1's care plan edited on 3/20/24, identified R1 exhibited wandering and wandered to other units and front door. R1 wandered into other resident rooms and had a history of using the bathroom in inappropriate places. Interventions included R1 to have supervision when ambulating off the unit, redirection when wandering in others rooms, attempt to redirect back to unit if R1 walked off unit. Although the Behavior Observation Assessment	2 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00644	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 570	Continued From page 4 dated 3/20/24, identified R1 demonstrated disrobing in public behaviors the care plan was not revised to include the behavior(s). A facility reported incident (FRI) submitted to the State Agency (SA on 6/22/24 included staff noticed R1 in a male residents room with door was closed. Staff found R1 standing next to her wheelchair with her pants and brief down and near her knees. R1's care plan was not revised after the incident to include the behavior of disrobing until 6/27/24. R1's care plan was revised on 6/27/24, to include that R1 would occasionally remove clothing at inappropriate times and in appropriate places. No goal or interventions to manage the behavior were included. During an interview on 6/26/24 at 12:27 p.m., nursing assistant (NA)-A stated R1 did not always understand what staff say to her. She wandered frequently and went into other resident rooms and laid in their beds. NA-A stated R1 had been in seven or eight rooms that morning. "with R1 it is a thing for her to strip naked and walk the halls." During an interview on 6/26/24 at 1:18 p.m., NA-B stated R1 "liked to strip and walk down the hall, it was mainly bottoms down, but not the top, she did it a lot". NA-B stated there was no direction given on how to divert or stop it from happening. "Nothing has been put in the care plan for us and no one had directly told us anything about that. Miscommunication happens a lot". During an interview on 6/26/24 at 1:43 p.m., licensed practical nurse (LPN)-A stated R1 strips bottom half down anytime of the day. R1 typically would strip in her room and then go into the	2 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00644	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 570	Continued From page 5 hallway. During an interview on 6/26/24 at 3:19 p.m., NA-D stated R1 strips her bottom half down most commonly in her room and then goes in the hallway. NA-D stated that one time she found her in the kitchen "stripped." During an interview on 6/26/24 at 3:26 p.m., NA-E stated that he has always seen R1 have her clothes off in her room and he would go in and redress her. NA-E stated that there was no direction given on how to proceed if R1 was unclothed in the hall. During an interview on 6/27/24 at 2:04 p.m., clinical manager (CM)-A stated unfortunately R1 did have a history of taking her clothes off anywhere, and frequently removed them. Recently she took them off at the dining room table. R1's family was aware of it, and they have brought in different textures of clothes and CM-A indicated she did not think that the texture or the size of the clothing was a factor in R1 removing her clothes. CM-A recommended redirection, aiding, and to keep R1 in eyesight as able to prevent the behavior. CM-A was not aware if the care plan had interventions in place for R1 disrobing. During an interview on 6/28/24 at 10:15 a.m., with Regional Director of Clinical Services-South Region (RDSCS), Director of Nursing (DON) and Administrator were present. DON stated there was not a specific assessment for wandering in rooms and undressing. DON explained it was common for R1 to wander due to her cognition level and her care was updated on 6/27/24 to include removal of clothing at inappropriate times and places. DON stated assessments were	2 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00644	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 570	Continued From page 6 completed, and care plans created so staff have appropriate interventions to maintain safety and continuity of care. The facilities Comprehensive Assessments and Care Planning policy revision dated 9/27/23, identified that 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 practicable physical, mental and psychological functioning possible, a facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. 7. a facility should use the results of the assessment to develop, review and revise the resident's person-centered comprehensive care plan. 8. 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 assistant assigned to the resident and culinary staff. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00644	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER KODA LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW OWATONNA, MN 55060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	