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,

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

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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,

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

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August 9, 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 informed you of imposed enforcement remedies.

On July 24, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567. Because corrective action was taken prior to the survey for the F689, it was issued at past non-compliance and does not require a plan of correction (POC).

In addition, at the time of this survey, we identified the following deficiency. This deficiency does require a plan of correction.

F609 Reporting of Alleged Violations - S/S D

REMOVAL OF IMMEDIATE JEOPARDY

On July 22, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 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.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

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.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Please note that Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Koda Living Community is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 24, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800)397-6124 for specific information regarding a waiver for these programs from this Department.

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,

Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 9, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: W7LP11

Dear Administrator:

The above facility was surveyed on July 23, 2024 through July 24, 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 <u>only a suggestion</u> 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.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 07/24/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/23/24 thru 7/24/24, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. The IJ at F689 began on 7/21/24, when R1 fell from a mechanical lift, R1 sustained fractured sternum and a left pelvis hematoma that required hospital admission and blood transfusion. The IJ was removed on 7/22/24, when the facility had implemented immediate corrective action to prevent recurrence, therefore, the IJ was issued at PAST NON-COMPLIANCE. The following complaints were reviewed: H54266186C (MN00105103 and MN00105106) with deficiencies cited at F609 and F689 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	Past noncompliance: no plan of correction required.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		8/20/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/15/2024

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 1 §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 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 observation, interview and document review, the facility failed to ensure the administrative staff and State Agency (SA) were notified immediately but no later than 2 hours of an allegation of neglect for 1 of 1 resident R1 who fell from a mechanical lift. Findings include:	F 609	• Facility filed incident report with MDH on 07/22/2024. Incident for R1 investigated and submitted for final review on 07/26/2024. • R1s care plan reviewed and updated as necessary to reflect investigation findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 2 A facility reported incident was submitted to the state agency (SA) on 7/22/24, at 1:34 p.m. The incident report identified R1 experienced fall during transfer from chair to bed. R1's quarterly Minimum Data Set (MDS) dated 6/19/24 indicated R1 had intact cognition, with diagnoses of muscle weakness. R1 was dependent on staff for transfers, took anticoagulants and had no history of falls. R1's progress note dated 7/21/24 at 9:40 p.m., indicated R1 had a fall from a mechanical lift the resulted in skin tears to her right index and middle fingers and left bicep area. During an interview on 7/24/24 at 1:01 p.m., director of nursing (DON) indicated that she was made aware of R1's fall that had occured on 7/21/24 on 7/22/24 at 8:03 a.m. DON stated it was her expectation that any fall with injury or fall from mechanical lift was reported to her or the on-call nurse, provider, and family members immediately but no later than 2 hours. Review of the facility's policy dated indicated: 9. Reporting of Suspected Resident Abuse and/or Neglect a. Staff will notify the facility Charge of Building immediately of any reports of possible abuse, neglect, misappropriation of resident property, and/or financial exploitation. The Charge of Building will immediately notify the Executive Director or designee in the ED's absence. b.The community is responsible for reporting suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation in accordance with legal requirements. If the event that caused the suspicion involves abuse or	F 609	• All facility falls involving mechanical lifts were reviewed to ensure proper reporting guidelines were completed. • Facility process updated to include falls involving mechanical lifts be reviewed to ensure immediate reporting to facility on-call nurse, DON, or administrator in order to complete initial report to state agency within 2 hours. • All licensed nursing staff will be re-educated on Abuse Prevention Policy (SS018); specifically related to timely reporting when fall involving a mechanical left has occurred. • Review of falls involving mechanical lifts will be completed weekly for 6 weeks for immediate notification and timely reporting of on-call nurse/DON/administrator. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 3 results in serious bodily injury, the individual is required to report the suspicion immediately, but not later than 2 hours after forming the suspicion. If the event does not involve abuse and does not result in bodily injury, the individual is required to report no later than 24 hours after forming the suspicion.	F 609		
F 689 SS=J	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 interview and document review the facility failed to safely use a mechanical lift per manufactures recommendations to transfer 1 of 1 resident (R1), who required a mechanical lift for transfers. This resulted in an immediate jeopardy (IJ) when R1 fell from a full body mechanical lift causing R1 to sustain a fractured sternum and left pelvic hematoma that required a hospital admission and blood transfusion. The IJ began on 7/21/24 at 9:40 p.m., when staff failed to ensure lift sling was properly secured prior to the transfer causing R1 to fall from the mechanical lift. The administrator, regional nurse manager, and director of nursing (DON) were notified of the IJ on 7/24/24 at 4:13 p.m. The IJ was removed on 7/22/24, when the facility implemented immediate corrective action before	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 4	F 689		

survey to prevent recurrence, therefore, the IJ was issued at past non-compliance.

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 6/19/24, indicated R1' had intact cognition R1 used a motorized wheelchair, was dependent with all transfers, and did not walk. R1 took anticoagulants (blood thinners).

R1's mobility care plan dated 3/27/24, directed staff to transfer R1 with a full body mechanical lift (hoyer-brand name) using a medium sized sling and two staff. indicated transfers with hoyer lift.

R1's progress note dated 7/21/24 at 9:40 p.m., indicated licensed practical nurse (LPN)-A was called to room by nursing assistants (NA)s. When nurse entered room R1 was laying on the floor beside the bed. R1 stated she did not hit her head. R1 was assisted with hoyer lift to bed. NA-B and NA-S stated R1 was hooked up and lifted per protocols During the transfer R1 fell to the floor in the sling. NA-B and NA-S unaware what caused sling to fall. The note indicated R1 sustained skin tears to right index and middle finger that were covered with band aids, a skin tear with bruising to left bicep that measured 8.0 centimeters (cm) x 8.0 cm which was covered with a dressing, and bruising to the top of left shoulder. R1 declined being examined in the emergency department (ED).

R1's progress note dated 7/22/24 at 1:55 a.m., indicated R1 was reporting total body pain post fall and pain in upper left thigh that had light blue bruising, was slightly swollen and tender to touch. R1 requested and was given acetaminophen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 689	Continued From page 5	F 689		

(Tylenol) 650 milligrams (mg) approximately 1:40 a.m.

R1's progress note dated 7/22/24 at 3:34 a.m., R1 reported her neck and right side of her head hurt, no redness, swelling, bruising or any signs of injury. R1 declined to go to emergency department for further evaluation, ice pack was applied to right side of her head and neck.

R1's progress note dated 7/22/24 at 8:33 a.m, indicated R1 was transferred to the hospital.

R1's hospital records indicated on 7/22/24, R1 presented to a local emergency room however was then air lifted to a higher level hospital for further trauma evaluation. Records indicated R1 had concerning blood pressure of 68 with a repeat of 79/43 (normal is 110/70). Imaging identified R1 had acute to subacute nondisplaced transverse fracture of the manubruium (sternum) and a large left hip hematoma measuring 20.6 centimeters (cm) x 8.8 cm x 5.3 cm. Additionally, was given a diagnosis of anemia with a hemoglobin of 6.3 grams/deciliter (normal is for females is 12-16 g/dl) secondary to hemorrhage that required a blood transfusion.

During an interview on 7/24/24 at 8:37 a.m., family member (FM)-B stated R1 remained in the intensive care unit (ICU). R1 remains in the hospital.

During an interview on 7/23/24, (NA)-B indicated on 7/21/24 around 9:30 p.m. she was working with NA-S when R1 fell from the lift when they were transferring R1 off of the commode. NA-B indicated she was running the controls of the lift; she lifted R1 up into air off the commode. While

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	245426	A. BUILDING ______ B. WING ______	C 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689 Continued From page 6 F 689

R1 was suspended in the air NA-S performed peri-care. NA-B then started to push the lift towards R1's bed, that was when the upper right sling strap came off the hook of the lift and R1 fell approximately three feet to the floor. LPN-C was notified via radio of the fall. LPN-C arrived to the room and completed assessments. R1 sustained skin tears and complained of pain in both her shoulders. R1 was transferred off the floor to her bed using the same lift and sling she had just fallen from. LPN-C applied dressings to the wound and R1 was given ice packs for pain. NA-B indicated NA's had checked and confirmed they both used the same color sling straps were connected to the lift, however, could not articulate they had checked the tension of the straps once R1 was lifted up and prior to the transfer. NA-B stated she had received education on following the manufacturer's instructions after the incident.

During an interview on 7/24/24 at 12:50 p.m., NA-S stated she was working with NA-B on 7/21/24. They were transferring R1 from the commode to the bed when the top right strap came off the lift causing R1 to fall to the floor. NA-B called LPN-C on the radio, while NA-S stayed with R1. NA-S stated she did not know how the loop came off the lift. NA-S explained they had checked to ensure the same color straps were used however, did not articulate the placement and/or tension were checked after R1 was raised in the air and prior to the transfer to ensure the straps did not loosen or move. NA-S stated she had received education on how to complete safe lift transfers after R1's fall.

During an interview on 7/24/24 at 12:05 p.m., LPN-A stated on 7/21/24 at 9:40 p.m., she was called to R1's room as R1 fell from a mechanical

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F 689	Continued From page 7	F 689		

lift and was on the floor. LPN-A did an assessment of R1 prior to moving her, skin tears to right index and middle finger and able to move all major joints. LPN-A, NA-B and NA-S used the same sling and lift to get R1 off the floor and into bed. Once in bed staff noticed bruising and a skin tear to the left bicep. LPN-A indicated R1 refused to go to the hospital on her shift, however, was sent in on 7/22/24. LPN-A further stated since the incident, the procedure was to report falls from lifts immediately to the on-call nurse, DON, administrator as well as the provider immediately. LPN-A stated she received education on safe lift transfers following R1's fall.

Review of the facility's smart lift safety and maintenance checklist for the lifts dated 7/22/24 indicated that both lifts were inspected by maintenance per protocol, with no issues noted. Inspection of the slings were also completed, no frays or other damage was noted.

During an interview on 7/24/24 at 1:01 p.m., director of nursing (DON) explained the lift and sling that was involved in the incident were inspected, there were no issues found with either. The fall was likely a result of operator error because there were no issues found with the equipment. DON stated it was her expectation for staff to follow manufactures recommendations when using mechanical lifts. Equipment that is involved in accidents needs to be removed from operation and checked by Maintance to ensure the lift/lift accessories are safe to use. DON indicated all nursing staff were re-educated with return demonstration on using the mechanical lifts on 7/22/24.

During an interview on 7/24/24 at 11:50 a.m., lift

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F 689	Continued From page 8	F 689		

representative (LR)-A stated staff were to remove the lift and the lift sling from operation until maintenance can perform preventative maintenance per manufacture recommendations. LR-A explained staff needed to check the tension of the sling loops/straps by touching each one to make sure they are secured onto the lift. This check is completed while the resident is being lifted and still on/over the surface that they are being raised off of.

The immediate jeopardy that started on 7/21/24, was removed on 7/22/24 after it was verified the facility implemented the following corrective actions:
-On 7/22/24 the facility implemented re-education that included return demonstration to all nursing staff per the manufacture's recommendations prior to working the floor.
-On 7/22/24 maintenance inspected all the lifts for function and safety. Additionally checked the slings for any issues.
-Residents who used mechanical lifts were all reassessed to ensure proper sling size and confirmed accuracy of care plans by 7/22/24
-Facility contacted the manufacturer for additional in person re-iteration of training on 7/25/24
-On 7/22/24, the facility revised policy/procedure to include that all falls are reported to the nurse on call, provider, and family of significant falls, even when resident ask staff to not notify.
-On 7/22/24, the facility revised their post fall follow up to include documentation and monitoring guidelines, anticoagulation, vital sign and assessment with neuro checks if hit head.

EZ-Way Smart Lift Operator Manual included the following:
-the EZ Way Smart Lift was designed to lift

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F 689	Continued From page 9 patient/resdient's from bed, chair, toilet and floor. -all washable EZ Way slings are capable of bearing a 1,000 pounds weight load, but must only be used to hold the amount of weight dictated by the EZ Way Smart Lift capacity. -do not modify the sling design in any way, make the accessories used with each lift are appropriate for both the patient and the transferring situation. -all EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided. -while lifting the patient upward, continue until there is tension on the sling legs, making sure all the loops on the sling are securely hooked on the hanger bars before moving resident from over the surface transferring from.	F 689		

Minnesota Department of Health

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2 000	Initial Comments	2 000		

*****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 7/23/24 thru 7/24/24, 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 have reviewed these orders and

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54266186 (MN00105103 and MN00105106) with a licensing orders issued at 0830. 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 state form.	2 000		

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2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to safely use a mechanical lift per manufactures recommendations to transfer 1 of 1 resident (R1), who required a mechanical lift for transfers. This resulted in an immediate jeopardy (IJ) when R1 fell from a full body mechanical lift causing R1 to sustain a fractured sternum and left pelvic hematoma that required a hospital admission and blood transfusion. The IJ began on 7/21/24 at 9:40 p.m., when staff failed to ensure lift sling was properly secured	2 830	Corrected	8/20/24

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2 830	Continued From page 3 prior to the transfer causing R1 to fall from the mechanical lift. The administrator, regional nurse manager, and director of nursing (DON) were notified of the IJ on 7/24/24 at 4:13 p.m. The IJ was removed on 7/22/24, when the facility implemented immediate corrective action before survey to prevent recurrence, therefore, the IJ was issued at past non-compliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/19/24, indicated R1' had intact cognition R1 used a motorized wheelchair, was dependent with all transfers, and did not walk. R1 took anticoagulants (blood thinners). R1's mobility care plan dated 3/27/24, directed staff to transfer R1 with a full body mechanical lift (hoyer-brand name) using a medium sized sling and two staff. indicated transfers with hoyer lift. R1's progress note dated 7/21/24 at 9:40 p.m., indicated licensed practical nurse (LPN)-A was called to room by nursing assistants (NA)s. When nurse entered room R1 was laying on the floor beside the bed. R1 stated she did not hit her head. R1 was assisted with hoyer lift to bed. NA-B and NA-S stated R1 was hooked up and lifted per protocols During the transfer R1 fell to the floor in the sling. NA-B and NA-S unaware what caused sling to fall. The note indicated R1 sustained skin tears to right index and middle finger that were covered with band aids, a skin tear with bruising to left bicep that measured 8.0 centimeters (cm) x 8.0 cm which was covered with a dressing, and bruising to the top of left shoulder. R1 declined being examined in the emergency department (ED).	2 830		

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2 830	Continued From page 4	2 830		

R1's progress note dated 7/22/24 at 1:55 a.m., indicated R1 was reporting total body pain post fall and pain in upper left thigh that had light blue bruising, was slightly swollen and tender to touch. R1 requested and was given acetaminophen (Tylenol) 650 milligrams (mg) approximately 1:40 a.m.

R1's progress note dated 7/22/24 at 3:34 a.m., R1 reported her neck and right side of her head hurt, no redness, swelling, bruising or any signs of injury. R1 declined to go to emergency department for further evaluation, ice pack was applied to right side of her head and neck.

R1's progress note dated 7/22/24 at 8:33 a.m, indicated R1 was transferred to the hospital.

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During an interview on 7/24/24 at 8:37 a.m., family member (FM)-B stated R1 remained in the intensive care unit (ICU). R1 remains in the hospital.

During an interview on 7/23/24, (NA)-B indicated on 7/21/24 around 9:30 p.m. she was working

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2 830	Continued From page 5	2 830		

with NA-S when R1 fell from the lift when they were transferring R1 off of the commode. NA-B indicated she was running the controls of the lift; she lifted R1 up into air off the commode. While R1 was suspended in the air NA-S performed peri-care. NA-B then started to push the lift towards R1's bed, that was when the upper right sling strap came off the hook of the lift and R1 fell approximately three feet to the floor. LPN-C was notified via radio of the fall. LPN-C arrived to the room and completed assessments. R1 sustained skin tears and complained of pain in both her shoulders. R1 was transferred off the floor to her bed using the same lift and sling she had just fallen from. LPN-C applied dressings to the wound and R1 was given ice packs for pain. NA-B indicated NA's had checked and confirmed they both used the same color sling straps were connected to the lift, however, could not articulate they had checked the tension of the straps once R1 was lifted up and prior to the transfer. NA-B stated she had received education on following the manufacturer's instructions after the incident.

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2 830	Continued From page 6	2 830		

During an interview on 7/24/24 at 12:05 p.m., LPN-A stated on 7/21/24 at 9:40 p.m., she was called to R1's room as R1 fell from a mechanical lift and was on the floor. LPN-A did an assessment of R1 prior to moving her, skin tears to right index and middle finger and able to move all major joints. LPN-A, NA-B and NA-S used the same sling and lift to get R1 off the floor and into bed. Once in bed staff noticed bruising and a skin tear to the left bicep. LPN-A indicated R1 refused to go to the hospital on her shift, however, was sent in on 7/22/24. LPN-A further stated since the incident, the procedure was to report falls from lifts immediately to the on-call nurse, DON, administrator as well as the provider immediately. LPN-A stated she received education on safe lift transfers following R1's fall.

Review of the facility's smart lift safety and maintenance checklist for the lifts dated 7/22/24 indicated that both lifts were inspected by maintenance per protocol, with no issues noted. Inspection of the slings were also completed, no frays or other damage was noted.

During an interview on 7/24/24 at 1:01 p.m., director of nursing (DON) explained the lift and sling that was involved in the incident were inspected, there were no issues found with either. The fall was likely a result of operator error because there were no issues found with the equipment. DON stated it was her expectation for staff to follow manufactures recommendations when using mechanical lifts. Equipment that is involved in accidents needs to be removed from operation and checked by Maintance to ensure the lift/lift accessories are safe to use. DON indicated all nursing staff were re-educated with return demonstration on using the mechanical lifts on 7/22/24.

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2 830	Continued From page 7 During an interview on 7/24/24 at 11:50 a.m., lift representative (LR)-A stated staff were to remove the lift and the lift sling from operation until maintenance can perform preventative maintenance per manufacture recommendations. LR-A explained staff needed to check the tension of the sling loops/straps by touching each one to make sure they are secured onto the lift. This check is completed while the resident is being lifted and still on/over the surface that they are being raised off of. The immediate jeopardy that started on 7/21/24, was removed on 7/22/24 after it was verified the facility implemented the following corrective actions: -On 7/22/24 the facility implemented re-education that included return demonstration to all nursing staff per the manufacture's recommendations prior to working the floor. -On 7/22/24 maintenance inspected all the lifts for function and safety. Additionally checked the slings for any issues. -Residents who used mechanical lifts were all reassessed to ensure proper sling size and confirmed accuracy of care plans by 7/22/24 -Facility contacted the manufacturer for additional in person re-iteration of training on 7/25/24 -On 7/22/24, the facility revised policy/procedure to include that all falls are reported to the nurse on call, provider, and family of significant falls, even when resident ask staff to not notify. -On 7/22/24, the facility revised their post fall follow up to include documentation and monitoring guidelines, anticoagulation, vital sign and assessment with neuro checks if hit head. EZ-Way Smart Lift Operator Manual included the following:	2 830		

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 ______	07/24/2024

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) COMPLETE DATE
2 830	Continued From page 8 -the EZ Way Smart Lift was designed to lift patient/resdient's from bed, chair, toilet and floor. -all washable EZ Way slings are capable of bearing a 1,000 pounds weight load, but must only be used to hold the amount of weight dictated by the EZ Way Smart Lift capacity. -do not modify the sling design in any way, make the accessories used with each lift are appropriate for both the patient and the transferring situation. -all EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided. -while lifting the patient upward, continue until there is tension on the sling legs, making sure all the loops on the sling are securely hooked on the hanger bars before moving resident from over the surface transferring from. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		