



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
October 9, 2024

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

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

Dear Administrator:

On October 8, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa 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](mailto:Melissa.Poepping@state.mn.us)



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Electronically delivered

October 9, 2024

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

Re: Reinspection Results  
Event ID: 2Z9O12

Dear Administrator:

On October 8, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 6, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa 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](mailto:Melissa.Poepping@state.mn.us)



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
September 13, 2024

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

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

Dear Administrator:

On September 6, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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.

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

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

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

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

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

#### DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by December 6, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 6, 2025 (six months after the

Koda Living Community

September 13, 2024

Page 3

identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:  
[https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, 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](mailto:Melissa.Poepping@state.mn.us)

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

PRINTED: 09/20/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245426</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/06/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KODA LIVING COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2255 30TH STREET NW</b> <b>OWATONNA, MN 55060</b>
--	--

(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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 9/6/24, 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.</p> <p>The following complaints were reviewed: H54267788C (MN00106357) and H54267788C (MN00106343) with a deficiency cited at F689.</p> <p>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.</p> <p>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.</p>	F 000		
F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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 record review the facility failed to follow the care plan for transfers for 1 of</p>	F 689	<ul style="list-style-type: none"> <li>Care plan for R1 was reviewed and revised as necessary.</li> </ul>	10/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>09/20/2024</b>
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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.

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

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NAME OF PROVIDER OR SUPPLIER  <b>KODA LIVING COMMUNITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2255 30TH STREET NW</b> <b>OWATONNA, MN 55060</b>		
(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 689	<p>Continued From page 1</p> <p>3 residents (R1) who sustained a fall as a result.</p> <p>Findings include:</p> <p>R1's face sheet dated 9/6/24, identified R1's diagnoses included hemiplegia and hemiparesis affecting right dominant side (affect movement and sensation on one side of the body), metabolic encephalopathy (alteration in consciousness caused by diffuse or global brain dysfunction), muscle weakness, and epilepsy (brain disease that causes repeated seizures due to abnormal electrical signals).</p> <p>R1's comprehensive Minimum Data Set (MDS) dated 5/31/24, identified R1 did not have cognitive impairment. R1 required substantial assistance to transfer from one position to another.</p> <p>R1's care plan dated 5/20/24, identified R1 required assist of one staff with non-mechanical sit to stand aid for all transfers. R1's care plan dated 7/24/24 identified R1 required assist of two with non-mechanical sit to stand aid for transfers. Both interventions were discontinued on 9/4/24.</p> <p>R1's progress note dated 7/24/24, identified R1 was assist of two staff with non-mechanical sit to stand lift. Therapy also completed a short blessed test (SBT) test with a score of 16/28 indicating cognitive impairment consistent with dementia.</p> <p>R1's physical therapy note dated 8/1/24, identified therapy and unit coordinator transferring R1 with contact guard assist with the sit to stand.</p> <p>R1's progress note dated 8/23/24, identified R1 was to continue with assist of two with</p>	F 689	<ul style="list-style-type: none"> <li>All residents with falls from 9/26/24 to current will be reviewed by facility IDT team to ensure care plan for transfers was followed at the time of the incident.</li> <li>All nursing staff will be re-educated on Comprehensive Care Planning (NS101); specifically related following care plan for all transfers. Education will include where to locate resident's current care plan for transfer status.</li> <li>Review of all facility falls will be completed for 6 weeks to ensure care plan for transfers was followed. 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.</li> </ul>	

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NAME OF PROVIDER OR SUPPLIER  <b>KODA LIVING COMMUNITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2255 30TH STREET NW</b> <b>OWATONNA, MN 55060</b>		
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F 689	<p>Continued From page 2</p> <p>non-mechanical sit to stand lift for all self cares.</p> <p>R1's fall event report dated 9/2/24, identified R1 fell in the bathroom during a transfer from the toilet. The report identified R1 used a non-mechanical sit-to-stand lift for all transfers with two staff. R1 had been placed in the bathroom by two staff approximately 45 minutes prior to the fall and at the time of the fall R1 was only assisted with one nursing assistant. R1 reported her left foot got caught on the door frame during the transfer.</p> <p>R1's hospital after visit summary dated 9/4/24, identified R1 presented to the emergency department on 9/2/24, for a fall that resulted in left sided hip pain. R1 required lab work, x-ray of the left hip and pelvis, CT of cervical and lumbar spine, IV for pain management. The summary of these tests concluded R1 did not have any fractures as a result of the fall. R1 remained in the hospital until 9/4/24 for pain management.</p> <p>R1's care plan dated 9/4/24, identified R1 required assist of two with mechanical lift (hoyer) and large sling until further notified by therapy.</p> <p>During an interview on 9/6/24 at 10:42 a.m., nursing assistant (NA)-A stated residents have a white board in their room, a paper sheet they print daily, and a kardex on the computer that will tell them how a resident transfers.</p> <p>During an interview on 9/6/24 at 10:59 a.m., R1 was in her room sitting in her recliner with an evident right sided lean. R1 stated on 9/2/24, nursing assistant (NA)-B came to the bathroom to help her transfer from the toilet and moved the sit-to-stand machine too fast when transferring</p>	F 689		

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NAME OF PROVIDER OR SUPPLIER  <b>KODA LIVING COMMUNITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2255 30TH STREET NW</b> <b>OWATONNA, MN 55060</b>		
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F 689	<p>Continued From page 3</p> <p>her off the toilet. R1 stated NA-B pulled on her body and got her in the corner of the bathroom and she went down hard on the floor.</p> <p>During an interview on 9/6/24 at 1:26 p.m., NA-B stated R1's call light was sounding on 9/2/24 around 5:58 a.m., NA-B went to the room to answer the light. R1 was in the bathroom with the sit-to-stand. NA-B had R1 stand on the sit to stand to clean her from after toilet use. "I have done this before with her and she was really good and would stand while getting wiped." NA-B stated she was on R1's left side and pulled R1 back a little from the toilet to wipe her bottom and that is when R1 slipped from the stand. NA-B stated she placed her leg on R1's backside and gently lowered her to the ground. NA-B stated the call light was on the entire time to alert a staff member to assist with the transfer.</p> <p>During an interview on 9/6/24 at 11:42 a.m., PT-A stated R1's muscle tone has decreased since the fall. Prior to the fall R1 had been able to lean forward and assist with using the sit-to-stand without difficulties. During a follow-up interview at 3:12 p.m., PT-A stated R1 required the use of the sit-to-stand aide because R1 could not stand well. PT-A indicated there were "paddles" on each side of the lift that should be used when residents are in the standing position so that if they did become weak/off balance the paddles would provide support and reduce the risk of a fall. PT-A would not move R1 at all with the paddles of the sit-to-stand in place. R1 would need the paddles flipped down and in a seated position, "that would be against everything we learned." PT-A verified standing up from a surface onto the sit-to-stand is considered a transfer and would require two people to assist R1.</p>	F 689		

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NAME OF PROVIDER OR SUPPLIER  <b>KODA LIVING COMMUNITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2255 30TH STREET NW</b> <b>OWATONNA, MN 55060</b>		
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F 689	<p>Continued From page 4</p> <p>During an interview on 9/6/24 at 3:24 p.m., director of nursing (DON) stated it is considered part of the transfer to stand a resident up and she would expect the staff to follow the care plan. DON stated she expected NA-B to use two people when performing the transfer on R1 as per the care plan. DON provided education to NA-B with a return demonstration on using the sit-to-stand lift.</p> <p>The EZ way Stand Aid Operators Instructions undated, identified the sit to stand non-mechanical lift (transfer assist unit) keeps residents active and engaged in the transferring process. Transfers are quick and require minimal caregiver assistance. Users simply grasp the middle bar and pull themselves up. A padded split seat swings out for loading or unloading then swings back and locks to form a comfortable, secure seat for transport. It is an excellent alternative to a wheelchair for easier commode access.</p> <p>For safe operation of the EZ Way Stand Aid, operators should read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients.</p>	F 689		



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
September 13, 2024

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

Re: State Nursing Home Licensing Orders  
Event ID: 2Z9O11

Dear Administrator:

The above facility was surveyed on September 6, 2024 through September 6, 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](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:  <b>00644</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/06/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KODA LIVING COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2255 30TH STREET NW OWATONNA, MN 55060</b>
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(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
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 9/6/24, 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 1665. Please indicate in your electronic plan of correction you have reviewed these orders and</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>09/20/24</b>
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00644</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/06/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KODA LIVING COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2255 30TH STREET NW OWATONNA, MN 55060</b>
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(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
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2 000	<p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaints were reviewed: H54267788C (MN00106357) and H54267788C (MN00106343) with a licensing order issued at 0830.</p> <p>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.</p> <p>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 &lt;<a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a>&gt; 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</p>	2 000		
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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		
2 830	<p>MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to follow the care plan for transfers for 1 of 3 residents (R1) who sustained a fall as a result.</p> <p>Findings include:  R1's face sheet dated 9/6/24, identified R1's diagnoses included hemiplegia and hemiparesis affecting right dominant side (affect movement and sensation on one side of the body), metabolic encephalopathy (alteration in consciousness</p>	2 830	Corrected	10/1/24

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2 830	<p>Continued From page 3</p> <p>caused by diffuse or global brain dysfunction), muscle weakness, and epilepsy (brain disease that causes repeated seizures due to abnormal electrical signals).</p> <p>R1's comprehensive Minimum Data Set (MDS) dated 5/31/24, identified R1 did not have cognitive impairment. R1 required substantial assistance to transfer from one position to another.</p> <p>R1's care plan dated 5/20/24, identified R1 required assist of one staff with non-mechanical sit to stand aid for all transfers. R1's care plan dated 7/24/24 identified R1 required assist of two with non-mechanical sit to stand aid for transfers. Both interventions were discontinued on 9/4/24.</p> <p>R1's progress note dated 7/24/24, identified R1 was assist of two staff with non-mechanical sit to stand lift. Therapy also completed a short blessed test (SBT) test with a score of 16/28 indicating cognitive impairment consistent with dementia.</p> <p>R1's physical therapy note dated 8/1/24, identified therapy and unit coordinator transferring R1 with contact guard assist with the sit to stand.</p> <p>R1's progress note dated 8/23/24, identified R1 was to continue with assist of two with non-mechanical sit to stand lift for all self cares.</p> <p>R1's fall event report dated 9/2/24, identified R1 fell in the bathroom during a transfer from the toilet. The report identified R1 used a non-mechanical sit-to-stand lift for all transfers with two staff. R1 had been placed in the bathroom by two staff approximately 45 minutes prior to the fall and at the time of the fall R1 was only assisted with one nursing assistant. R1</p>	2 830		

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2 830	<p>Continued From page 4</p> <p>reported her left foot got caught on the door frame during the transfer.</p> <p>R1's hospital after visit summary dated 9/4/24, identified R1 presented to the emergency department on 9/2/24, for a fall that resulted in left sided hip pain. R1 required lab work, x-ray of the left hip and pelvis, CT of cervical and lumbar spine, IV for pain management. The summary of these tests concluded R1 did not have any fractures as a result of the fall. R1 remained in the hospital until 9/4/24 for pain management.</p> <p>R1's care plan dated 9/4/24, identified R1 required assist of two with mechanical lift (hoyer) and large sling until further notified by therapy.</p> <p>During an interview on 9/6/24 at 10:42 a.m., nursing assistant (NA)-A stated residents have a white board in their room, a paper sheet they print daily, and a kardex on the computer that will tell them how a resident transfers.</p> <p>During an interview on 9/6/24 at 10:59 a.m., R1 was in her room sitting in her recliner with an evident right sided lean. R1 stated on 9/2/24, nursing assistant (NA)-B came to the bathroom to help her transfer from the toilet and moved the sit-to-stand machine too fast when transferring her off the toilet. R1 stated NA-B pulled on her body and got her in the corner of the bathroom and she went down hard on the floor.</p> <p>During an interview on 9/6/24 at 1:26 p.m., NA-B stated R1's call light was sounding on 9/2/24 around 5:58 a.m., NA-B went to the room to answer the light. R1 was in the bathroom with the sit-to-stand. NA-B had R1 stand on the sit to stand to clean her from after toilet use. "I have done this before with her and she was really good</p>	2 830		

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2 830	<p>Continued From page 5</p> <p>and would stand while getting wiped." NA-B stated she was on R1's left side and pulled R1 back a little from the toilet to wipe her bottom and that is when R1 slipped from the stand. NA-B stated she placed her leg on R1's backside and gently lowered her to the ground. NA-B stated the call light was on the entire time to alert a staff member to assist with the transfer.</p> <p>During an interview on 9/6/24 at 11:42 a.m., PT-A stated R1's muscle tone has decreased since the fall. Prior to the fall R1 had been able to lean forward and assist with using the sit-to-stand without difficulties. During a follow-up interview at 3:12 p.m., PT-A stated R1 required the use of the sit-to-stand aide because R1 could not stand well. PT-A indicated there were "paddles" on each side of the lift that should be used when residents are in the standing position so that if they did become weak/off balance the paddles would provide support and reduce the risk of a fall. PT-A would not move R1 at all with the paddles of the sit-to-stand in place. R1 would need the paddles flipped down and in a seated position, "that would be against everything we learned." PT-A verified standing up from a surface onto the sit-to-stand is considered a transfer and would require two people to assist R1.</p> <p>During an interview on 9/6/24 at 3:24 p.m., director of nursing (DON) stated it is considered part of the transfer to stand a resident up and she would expect the staff to follow the care plan. DON stated she expected NA-B to use two people when performing the transfer on R1 as per the care plan. DON provided education to NA-B with a return demonstration on using the sit-to-stand lift.</p> <p>The EZ way Stand Aid Operators Instructions</p>	2 830		
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2 830	<p>Continued From page 6</p> <p>undated, identified the sit to stand non-mechanical lift (transfer assist unit) keeps residents active and engaged in the transferring process. Transfers are quick and require minimal caregiver assistance. Users simply grasp the middle bar and pull themselves up. A padded split seat swings out for loading or unloading then swings back and locks to form a comfortable, secure seat for transport. It is an excellent alternative to a wheelchair for easier commode access.</p> <p>For safe operation of the EZ Way Stand Aid, operators should read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients.</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b> 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 interventions 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.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Twenty-one (21) days.</p>	2 830		