Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 29, 2025

Administrator
Koda Living Community
2255 30TH STREET NW
OWATONNA, MN 55060

RE: CCN: 245426
Cycle Start Date: July 9, 2025

Dear Administrator:

On July 9, 2025, 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 actual harm that was not immediate jeopardy (Level G). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

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.

• 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.

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 $13,343; 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.

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

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
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

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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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. A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KODA LIVING COMMUNITY	2255 30TH STREET NW , OWATONNA, Minnesota, 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
F0000	INITIAL COMMENTS On 7/3/25, 7/8/25 and 7/9/25, 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 complaints were reviewed: H54268327C (MN00114192) with a deficiency issued at F689 issued at PAST NON-COMPLIANCE. 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.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure safe transfers with a full body mechanical lift for 1 of 3 residents (R1) reviewed for falls/safety. This resulted in actual harm when R1 fell from the lift, had severe back pain, and	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

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F0689 SS = G	Continued from page 1 needed to be sent to the emergency department (ED) for evaluation. The facility implemented immediate corrective action, so the deficient practice was issued at past non-compliance. Findings include: R1's face sheet dated 7/9/25, identified diagnoses of paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), acquired absence of left leg above the knee, and burst fracture of the T11-T12 vertebrae (a serious spinal injury when the vertebra breaks). R1's quarterly Minimum Data Set (MDS) dated 5/27/25, identified R1 was dependent on staff for all transfers and cognitively intact. R1 had no falls since previous assessment. R1's Safe Lifting and Movement assessment dated 5/21/25, identified R1 had an amputation, paraplegia, and required two persons transfer using a full mechanical lift. R1's mobility focus care plan dated 10/13/20, identified R1 had limited ability to transfer self, related to lower body paraplegia. Interventions included: assist of two with total mechanical lift and large amputee sling. R1's fall focus care plan dated 9/14/20, identified R1 was at risk for recurrent falls related to lower body paraplegia, left leg above the knee amputation (AKA), and use of total mechanical lift for transfers. Interventions included: R1 needed an large amputee sling, two staff for all mechanical lift transfers, and remind resident not to lean forward during total mechanical lift transfers. R1' s fall event dated 6/25/25 at 3:00 p.m., identified R1 had a witnessed fall from the total mechanical lift) while being transferred from wheelchair to bed. R1 stated he fell out of the total mechanical lift. R1 complained of severe pain "all over". Immediate intervention of assist of three for all total mechanical lift transfers was put into place. Review of R1 care plan identified revision on 6/25/25 to reflect the aforementioned intervention. R1's progress note dated 6/25/25 at 3:34 p.m., identified R1 found lying on the floor on his back with his head towards the wall. R1 was being transferred with the total mechanical lift into bed and the sling slipped out of the lift and resident landed on the	F0689		

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F0689 SS = G	Continued from page 2 floor. R1 was assisted back into bed and was then sent by emergency management services (EMS) for evaluation. R1's emergency department (ED) notes dated 6/25/25, identified R1 was seen in the ED for evaluation after a fall from elevation when lift strap broke causing patient to slide down onto floor, hit back of his head and left side. R1 noted pain in the back of head and had tenderness along midline thoracic spine. Computed tomography (CT) of brain, abdomen, pelvis, and cervical spine did not identify any hemorrhage or fractures. R1 was discharged back to the skilled nursing facility. R1's progress note dated 6/25/25 at 6:55 p.m., identified R1 returned from ED with no new orders and no fractures from the fall. R1's progress note dated 6/26/25 at 1:53 a.m., R1 reporting during repositioning he was in pain, particularly his chronic pain was bothering him. R1 rated pain six out of ten in a pain scale and was given an as needed pain medication. R1's medication administration record (MAR) identified on 6/26/25 R1 received a one dose of opioid narcotic pain medication and had not received any dose since 6/13/25. R1's progress note dated 6/26/25, identified a fall screen was completed by occupational therapy and recommended physical therapy (PT) for transfers, positioning, and bed mobility. R1's progress note dated 6/30/25, identified R1 had a PT evaluation completed and R1 would benefit from ongoing services for range of motion and low chronic back pain. R1 and spouse declined PT at this time. Additionally recommend wheelchair assessment for positioning, pressure offloading, and ease of mechanical lift transfers (i.e., reclining wheelchair), however, R1 and spouse declined, stating "he is happy with current wheelchair". Recommended returning to assist of two staff for mechanical lift for all transfers. During an interview on 7/9/25 at 11:40 a.m., physical therapist (PT)-G stated she performed R1 evaluation on 6/30/25 and did not observe any concern during the transfer. R1 did not have any shift of weight and had proper body positioning during the transfer. The correct size sling was being used and did not feel the need to have three staff were needed for the transfer, therefore she recommended to return to assist of two for all transfers with the total mechanical lift.	F0689		

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F0689 SS = G	Continued from page 3 R1's interdisciplinary team (IDT) note dated 7/1/25, identified the IDT team met to discuss R1's fall on 6/25/25. R1 was being transferred from wheelchair to bed when he fell from the total mechanical lift sling. R1 had been slowly rotated at the same time he was being lifted from the chair when family member (FM)-A began removing his wheelchair from underneath R1. Staff and FM-A reported R1 was 10-12 inches above his wheelchair seat when he fell, landing on the edge of the wheelchair and slid down to the foot pedal. R1 complained of increased neck and back pain and had three abrasions on left elbow. R1 was transferred to the ED for evaluation and found to have no fractures. Root cause of fall was related to R1 being rotated at the same time his wheelchair being removed, potentially causing weight to shift and sling loop to obtain enough slack to slide off hook on the lift. Immediate intervention of assist of three for all transfers. Physical and occupational therapy to evaluate transfers and recommended to resume assist of two for transfers with the total mechanical lift. R1's care plan was revised on 7/7/25 to reflect resume assist of two for all transfer with the total mechanical lift. During an interview on 7/8/25, licensed practical nurse (LPN)-A stated, R1's care plan was not revised to assist of two for the total mechanical lift transfers until 7/7/25, due to the facility wanted to ensure all of the transfers were going "well" with the resident before they revised the care plan back to assist of two for all transfers with the total mechanical lift During an interview on 7/8/25 at 10:30 a.m., FM-A stated she was present at the time R1 fell out of the lift on 6/25/25. FM-A stated nursing assistant (NA)-F and NA-I hooked R1's sling to the total mechanical lift, and when R1 was being lifted out of his wheelchair about a foot above it, one of the straps by R1's left shoulder came off the hook and R1 slid to the floor. R1 was hanging from the lift head towards the floor when NA-F and NA-I lowered R1 to the floor. FM-A states she will assist staff by pulling R1's wheelchair out from under R1 during transfers and will look at the sling straps to ensure all the straps are hooked correctly, however she did not check that day. R1 was then lifted back into bed; he later had pain and had to be sent to the emergency department (ED) for evaluation because R1 was having "terrible" pain all over. During an interview on 7/8/25 at 2:10 p.m., NA-F stated that her and NA-I were performing a transfer of R1	F0689		

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F0689 SS = G	Continued from page 4 using the total mechanical lift, and as they were lifting R1 out of the wheelchair they began to turn R1 towards the bed when they needed to adjust R1's right foot so it would not hit the bed. R1's FM-A was removing R1's wheelchair from under R1 when the sling became unhooked from under R1's left shoulder and R1 began to slide down to the floor. NA-F further stated they hooked the sling correctly to the lift and double checked the tension; however, she thinks it could have been "user error" and "we might have forgotten to check something." During a follow up interview on 7/9/25 at 10:23 a.m., NA-F stated the only rationale she could think of what caused the fall was that "we must have done something wrong", however did not recall doing anything incorrect when R1 was attached to the total mechanical lift. During an interview on 7/9/25, licensed practical nurse (LPN)-B stated he was called to R1's room on 6/25/25 after R1 had a fall. R1 was observed lying on the floor with his head towards the wall, with the lift sling already unhooked and underneath R1. NA-F and NA-I had been doing a transfer of R1 from wheelchair to the bed and as R1 was being lifted, R1's right leg was positioned so it would not hit the bed, when one of the sling straps came loose and R1 fell to the floor. R1 was assessed and then lifted from the floor and placed back in bed. R1 was later sent to the ED due to severe pain, however, was found to have no fractures. R1 was changed to assist of three for all transfers. During an interview on 7/8/25 at 12:54 p.m., director of nursing (DON) stated after R1's fall on 6/25/25, the facility wanted to see if a different type of amputee sling (hourglass) may had been appropriate for R1 however, the total mechanical lift representative (MLR) came to the facility on 6/30/25 and determined the current type and size of sling was appropriate for transfers. R1 had been evaluated by physical therapy (PT) and recommended R1 could return to assist of two for all transfers using the total mechanical lift. During a subsequent interview at 3:51 p.m. DON stated it was her expectation for all staff to follow manufacture directions to ensure all residents were safely transferred using all mechanical lifts. DON further stated all staff had started re-education on safe lift transfers and following manufacture directions after R1's fall and audits were being done to ensure this is being done correctly. During an interview on 7/8/25 at 12:58 p.m., mechanical lift representative (MLR) stated she evaluated R1's sling and the lift had been used during R1's fall on 6/30/25 and found no issues with either. MLR explained	F0689		

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F0689 SS = G	Continued from page 5 the correct sling was used; if a resident's leg had been repositioned while in the sling, it would be difficult for a sling strap to become unhooked from the lift if it had been hooked up properly. MLR further stated that some things that could have been done incorrectly for a resident to slide out of the sling could be like double looping if the second loop was not hooked up correctly, pushing the lift over something while resident in the sling, or not having the legs of the lift when the resident being turned. Review of the facility's Use of Mechanical Lift policy dated 9/30/24, identified the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. Steps in the procedure include: -Before using a lifting device, assess the resident's current condition, including: Physical: Can the resident assist with transfer? Is the resident's weight and medical condition appropriate for the use of a lift? Cognitive/Emotional: Can the resident understand and follow instructions? Does the resident express fear or appear anxious about the use of a lift? Is the resident agitated, resistant, or combative? -Measure the resident for proper sling size and purpose, according to manufacturer's instructions. -Prepare the environment: Clear an unobstructed path for the lift machine. Ensure there is enough room to pivot. Position the lift near the receiving surface. Place the lift at the correct height. The following corrective actions were verified as implemented prior to the survey: -R1 was sent to the hospital on 6/25/25 and found to	F0689		

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F0689 SS = G	Continued from page 6 have no injuries identified during the evaluation. -Immediate intervention for R1 on 6/25/25 was to have staff assist of three for all transfers of R1 with the total mechanical lift. -On 6/25/25 an email communication was all nursing staff to remind about safe transfer procedures when using the total mechanical lift: to ensure weight is being distributed in the sling throughout the entire transfer and to be cautious when rotating the resident to not bump the wheelchair side to cause the resident's weight to shift; If notice resident's weight begin to shift while elevated in the sling to safely lower the resident back into the wheelchair or bed, ensure using the proper equipment, and ask for more assistance. -All like residents who utilized the total mechanical lifts were interviewed regarding transfers and no concerns noted. -All facility residents utilizing the mechanical lifts had sling sizing completed per manufactures guidelines. -All facility residents utilizing the mechanical lifts had care plans reviewed and revised as necessary to include lift and sling specifics. - R1 was evaluated by PT on 6/30/25 and no concerns with sling size and determined R1 could remain at assist of two for all transfers with the total mechanical lift. -Staff involved in the fall from the lift had re-training on safe lift and competency redone on 6/25/25 -Beginning on 6/25/25 education began with all nursing staff on safe transfers with total mechanical lifts -Total Mechanical Lift competency testing of all nursing staff began being completed on 6/25/25. -Audits of mechanical lift positioning during transfers are being completed on a 6-week tapering schedule for resident utilizing the mechanical lifts by the DON or designee -Audits will be brought to Quality Council after 6 weeks to determine need for ongoing and/or additional audits.	F0689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 29, 2025

Administrator
Koda Living Community
2255 30TH STREET NW
OWATONNA, MN 55060

Re: Event ID: OKKR11

Dear Administrator:

The above facility survey was completed on July 9, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Minnesota State Department of Health

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20000	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 7/3/25, 7/8/25 and 7/9/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State The following complaints were reviewed, H54268327C (MN00114192) with no licensing orders issued. Minnesota Department of Health is documenting the State	20000		

Office of Primary Care and Health Systems Management

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Minnesota State Department of Health

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20000	Continued from page 1 Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		