Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 17, 2025

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

RE: CCN: 245426
Cycle Start Date: October 24, 2024

Dear Administrator:

On November 6, 2024, we notified you a remedy was imposed. On December 2, 2024 the Minnesota Department of Health 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 November 26, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 6, 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 October 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 17, 2025

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

Re: Reinspection Results
Event ID: PUME12

Dear Administrator:

On December 2, 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 October 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 6, 2024

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

RE: CCN: 245426
Cycle Start Date: October 24, 2024

Dear Administrator:

On October 24, 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 immediate jeopardy (Level J), 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).

This survey also found other deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On October 17, 2024, the situation of immediate jeopardy to potential health and safety cited at F760 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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 24, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective January 24, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 24, 2025.

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

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

- Civil money penalty. (42 CFR 488.430 through 488.444)

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.

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 October 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.

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.

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 April 24, 2025 (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 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.

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)

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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 10/24/2024

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 10/22/24, 10/23/24, and 10/24/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54269546C (MN00107493), H54269558C (MN00107569), and H54269546C (MN00107635). A deficiency was issued at F760 at PAST NON-COMPLIANCE with additional deficiencies cited at F657, F684, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		11/26/24

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

Electronically Signed | 11/15/2024

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.

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F 657	Continued From page 1 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to revise the care plan for 2 of 9 residents reviewed (R1, R5) who had non-pressure related skin injuries. Findings include R1's face sheet dated 10/23/24, identified diagnoses of contusion to the head, fracture of facial bones, laceration without foreign body right lower leg, and nontraumatic subarachnoid hemorrhage. R1's care plan dated 9/16/23, identified R1 was at risk for falls related to history of falls and dependent on staff for transfers and ambulation. R1's progress note dated 10/10/24 at 7:04 p.m., identified R1 fell forward out of chair and landed on pavement with wheelchair landing on top of	F 657	" Care plans for R1 and R5 were reviewed and revised as necessary. " All facility residents with non-pressure related skin injuries had care plans reviewed and revised as necessary to include skin status and interventions. " All licensed nursing staff will be re-educated on Comprehensive Care Planning (NS101). Education will include care plan revisions for residents with non-pressure related skin injuries. " • Review of skin care plans will be completed three times a week for 4 weeks, then twice weekly for 4 weeks, then once a week for 4 weeks to ensure proper and timely revisions as necessary. 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	

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F 657	Continued From page 2 her. Lacerations to forehead, and cheek, bruising and swelling along with bleeding to nose, bleeding noted in mouth, large laceration to right shin/calf. 9-11 called to escort via ambulance to ED for evaluation. The care plan did not identify R1's impaired skin integrity nor a plan of care that included goals and individualized interventions from the fall on 10/10/24. During an interview on 10/23/24 at 8:45a.m., licensed practical nurse (LPN)-B stated R1 does not have a dressing on her leg, the stitches were removed the other day and it was just monitoring the leg. During an observation and interview on 10/24/24 at 10:26 a.m., LPN-B measured the wound to R1's right lower leg at 6.5x2 centimeters (cm). "I am surprised at how open it is after the stitches were removed." "The wound seems like it has some erythema or irritation to it." During an interview on 10/24/24 at 2:14 p.m., Infection Preventionist/Wound Nurse (IPWN)-A expected the floor nurses to notify her of wounds. Nothing was communicated except that R1 had scrapes and bruises. "If someone would have told me she had a wound she would have gotten on my list." IPWN-A updates care plans for wounds that are followed by her. During an interview on 10/24/24 at 12:37 p.m., nurse practitioner (NP)-A stated she was unaware of a thigh wound to R1's right leg. NP-A was aware of the fall but had not followed the wound care. The facility should have that in the care plan with interventions for staff to follow.	F 657	substantial compliance is not met.	

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F 657	Continued From page 3 R5's face sheet dated 10/24/24, identified diagnoses of surgical after care following surgery on the nervous system, burn of unspecified degree of left thigh, difficulty in walking, and muscle weakness. R5's comprehensive Minimum Data Set (MDS) dated 10/1/24, identified R5 had impairment on both sides of his lower body, and independent with wheelchair mobility. R5 was cognitively intact. R5's care plan dated 10/1/24, identified R5 was at risk for burn from hot liquids related to decreased sensory perception. R5's progress note dated 9/7/24 at 8:55 p.m., identified during weekly skin check R5 had a small red area from pizza burn that measured 0.5 x 0.3 cm. R5's physician encounter dated 9/27/24, identified R5 was seen for evaluation of left thigh burn due to placing hot popcorn directly on his thigh. Nursing had applied kerlix to the burn area. No signs of infection so Silvadene was ordered with kerlix wrap to prevent rubbing. Nursing to continue to check skin daily and current dressing. Burn measured 3.5 x 3.0 cm R5's progress note dated 10/8/24 at 1:38 p.m., identified discussion to ask for help to use microwave to prevent burns and safety. R5's care plan did not include the burns R5 received and the care plan was not revised to include the aforementioned intervention.	F 657		

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F 657	Continued From page 4 During an interview on 10/24/24 at 4:21 p.m., DON would expect the blisters to be in the care plan with interventions "I know it is not in his care plan to bring the popcorn back for him." During an interview on 10/24/24 at 12:37 p.m., NP-A stated she would expect the facility to notify her of all burns that occur. NP-A stated the clinic would follow the wound care if they were aware of it. The facility should have that in the care plan with interventions for staff to follow. The facility Resident/Family Participation in Care Planning policy dated 10/2/23, included: -Residents are informed of their rights and actively participate in person centered care planning per their discretion. -The resident has the right to see the care plan, including the right to sign after changes to it and to receive the services and/or items included in the plan. -The resident has the right to be informed, in advance, of the care to be furnished, the type of care giver or professional that will furnish care, and of changes to the plan of care. -Care conference documentation includes that staff resident and others that participate.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		11/26/24

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F 684	Continued From page 5 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to comprehensively assess, monitor, and notify the physician of new wounds for 2 of 3 residents (R1, R5) who had non-pressure related skin injuries. Findings include R1's face sheet dated 10/23/24, identified diagnoses of contusion to the head (bruise to the brain), fracture (break) of facial bones, laceration (cut) without foreign body right lower leg, and nontraumatic subarachnoid hemorrhage (bleeding below the arachnoid layer of the brain). R1's brief interview and staff assessment for mental status (BIMS) dated 7/29/24, identified R1 had severe cognitive impairment. R1's care plan dated 9/6/23, identified a potential for impaired skin integrity. Interventions included dressings per wound nurse or as ordered, monitor skin integrity weekly with showers, report to Nurse Practitioner (NP) or Medical Doctor as needed. R1's progress note dated 10/10/24 at 7:04 p.m., identified R1's chair rolled off the curb at approximately 6:30 p.m. R1 fell forward out of chair and landed on pavement with wheelchair landing on top of her. She received lacerations to forehead, and cheek, bruising and swelling along with bleeding to nose, mouth and had a large laceration to right shin/calf. R1 was sent to the emergency department (ED) for evaluation.	F 684	" R1 and R5 were assessed by facility licensed nursing associates and providers were updated on current wound status. Treatment and monitoring orders initiated per the provider□s recommendations. " All facility residents with non-pressure related skin injuries were assessed by facility licensed nursing associates and providers were updated on current wound status. Treatment and monitoring orders initiated per the provider□s recommendations. " All facility licensed nursing staff will be re-educated on Prevention and Treatment of Skin Breakdown Policy (NS1702). " • Review of scheduled weekly skin assessments will be completed three times a week for 4 weeks, then twice weekly for 4 weeks, then once a week for 4 weeks to ensure proper monitoring and provider notification. 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.	

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F 684	Continued From page 6 R1's ED visit note dated 10/10/24, identified laceration repair to right calf that was a complex clean 5-centimeter (cm) laceration. 10 milliliters (mL) of lidocaine (numbing agent) injected in skin. Irrigated (rinsed) with normal saline. No debridement (procedure to remove debris from wound) and wound explored, no foreign body found. R1's progress note dated 10/11/24 at 3:46 p.m., identified R1 returned from hospital with no new orders and had sutures in lower right leg. R1's physician order dated 10/11/24, identified a physician order to monitor laceration site on right lower leg for wound care once a day for signs/symptoms of infection. Keep covered. Another order dated 10/11/24, identified an order to remove sutures from right lateral calf on 10/21/24. R1's progress note dated 10/14/24 at 6:00 a.m., identified wound to right shin/calf stitches remain intact. Area is slightly red around the edges; some scabbing can be seen. No warmth or signs/symptoms of infection currently. R1's medication administration record (MAR) dated 10/23/24, included a physician order to monitor laceration site on right lower leg wound once a day for signs/symptoms of infection. Keep covered. Beginning 10/11/24 with no end date. Review of the MAR from 10/12/24-10/23/24, identified six administrations were marked with an asterisk (charting code that indicated "comment in reasons/comments"). One administration was marked parenthesis (charting code that indicated "not administered or not charted, see	F 684		

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KODA LIVING COMMUNITY	2255 30TH STREET NW OWATONNA, MN 55060

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F 684	Continued From page 7 reasons/comments.") Review of R1's progress notes did not include further information pertaining to the wound as indicated by the charting codes. Review of R1's record between 10/11/24 to 10/24/24, the record did not include a comprehensive assessment of the laceration, nor include documentation indicating the wound was continuously monitored for deterioration or improvement, signs/symptoms of infection, and administered treatments. During an interview on 10/23/24 at 8:45 a. m., licensed practical nurse (LPN)-B stated R1 did not have a dressing on her leg, the stitches were removed the other day and it was just monitoring the leg. During an observation and interview on 10/24/24 at 10:26 a.m., family member (FM)-A went to LPN-B and requested R1's dressing to her right lower leg be changed "it has been on there for a couple of days." R1 was in bed. LPN-B noted the dressing to her leg was not dated. It was an ABD dressing (thick absorbent dressing) with tape holding it in place. LPN-B removed the tape and started to pull off the ABD pad however, the dressing was adhered to the wound. R1 yelled out "ow!" while tape was being removed. LPN-B left room "to get water". R1 stated "I'd like to quit the hurting in my legs." LPN-B returned at 10:45 a.m., LPN-B used normal saline to wet the dressing. R1 continued to yell out "ow!" LPN-B described the drainage as scant and serosanguineous. Granulated blood and scab intact on the other side of the wound. "she had some stitches in it and they are removed now." LPN-B measured the wound 6.5 x 2.0 cm. LPN-B	F 684		

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F 684	Continued From page 8 applied a mepilex dressing and the adhesive border of the bandage was placed on the scabbed area of the wound. "I am surprised at how open it is after the stitches were removed." "The wound seems like it has some erythema (redness) or irritation to it." LPN-B verified the only order was to monitor the laceration site. During an interview on 10/24/24 at 12:37 p.m., nurse practitioner (NP)-A stated she was unaware of a wound to R1's right leg. NP-A was aware of the fall but has not followed the wound care. NP-A indicated care plans should be revised with interventions for staff to follow. During an observation and interview on 10/24/24 at 1:34 p.m., NP-A, IPWN-A and clinical manager (CM)-A went to R1's room to observe the dressing. NP-A verified the mepilex that was on R1's right lower leg wound was too small for the wound and was not covering the whole wound. IPWM-A measured the wound at 6.0 x 3.0 cm. NP-A requested staff use Vashe wound wash (sterile and cleans wounds), silver calcium alginate, mepilex, and get a wound culture for the wound. R1 stated the leg hurt. NP-A stated that it is definitely red around the wound. NP-A explained to IPWN-A the erythema needed to be measured. IPWN-A measured the erythema at 6.0 x 10.0 cm. NP-A explained to IPWN-A and CM-A the wound must be cleaned before obtaining the culture. NP-A used Vashe wash to rinse the wound. NP-A noted a suture was still in the wound and was located between 4 and 5 o'clock. IPWN-A stated if she would have been aware of the wound she would have been following R1. It was her understanding that R1 only had a scrape. IPWN-A stated the floor nurses were able to initiate wound care. NP-A did	F 684		

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F 684	Continued From page 9 not want to remove the suture as she was unable to find the knot. NP-A obtained the culture, requested a large mepilex be put on the wound, and sent R1 to the ED for removal of suture. R1's wound care order dated 10/24/24, identified right lower leg wound dressing once daily. Cleanse the wound with Vashe (wound cleanser that contains pure hypochlorous acid that helps fight bacteria and infection) and pat dry with sterile gauze. Apply a sterile silver calcium alginate (highly absorbent antimicrobial wound dressing that inhibits the growth of microorgansims inside the dressing) to fit the wound bed. Lightly moisten with Vashe- do not saturate. Cover with a mepilex (brand of dressing) foam dressing. R1's culture and sensitivity dated 10/27/24, identified results from the laceration to the right shin/calf as 4+ staphylococcus aureus. R1's prescription order dated 10/28/24, identified doxycycline hyclate (antibiotic) 100 milligrams (mg) take 1 capsule twice a day for a total of 20 doses. During an interview on 10/24/24 at 2:14 p.m., IPWN-A stated she was unaware how the floor nurses would notify her or document wounds. IPWN-A expected the floor nurses to notify her of wounds. Nothing was communicated except that R1 had scrapes and bruises. IPWN-A would expect the care plan to be updated with wounds, and wounds must be measured weekly. During an interview on 10/24/24 at 4:21 p.m., director of nursing (DON) stated the CM should follow any wound the wound nurse is not	F 684		

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F 684	Continued From page 10 following. The CM should get weekly measurements and document on wounds. DON was unaware how many sutures were in R1's wound and was unsure if the hospital provided the number of sutures they placed. DON would have expected a progress note identifying how many sutures were removed and the appearance of the wound when the sutures were removed. DON expected the floor nurses to notify the medical provider or IPWN-A of worsening wounds. IPWN-A can activate standing orders for wound care. DON verified IPWN-A was not certified for wound care. DON was not able to articulate education that IPWN-A received at facility but stated IPWN-A was in a wound nurse role at her previous job. DON was unaware of any competencies IPWN-A completed. DON verified medical doctor was at facility and removed two sutures from R1. The facility Prevention and Treatment of Skin Breakdown policy dated 9/1/18, identified skin is observed daily with cares, and weekly by licensed staff. Attending provider, resident and resident representative notified, supervisor, and dietitian notified. Weekly staging, measuring, and examination of the wound bed and surrounding skin. Notification to provider if deterioration occurred or no change in two weeks.	F 684		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 760	Past noncompliance: no plan of	

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F 760	Continued From page 11 review the facility failed to observe the rights of medication administration to ensure the right medication was safely administered for 1 of 3 residents (R2) reviewed for significant medication errors. This resulted in an immediate jeopardy for R2 who required hospitalization, continous monitoring and intravenous fluid recovery to return to baseline. The immediate jeopardy (IJ) began on 10/16/24 when licensed practical nurse (LPN)-A injected R2 with 100 units (U) of short-acting insulin instead of the prescribed Heparin (blood thinner that prevents blood clots) 5,000 milliliter (ml). The Administrator, Director of Nursing (DON), and clinical nurse manager were notified of the IJ on 10/23/24 at 5:13 p.m. The IJ was issued as past non-compliance (PNC) when facility implemented immediate corrective action prior to survey entrance to prevent recurrence. Findings include: R2's Continuity of Care document dated 10/23/24, identified R2 had diagnoses that included hypertensive chronic kidney disease with stage 5 chronic kidney disease (gradual loss of kidney function) with dialysis (treatment for kidney failure that filters and purifies blood using a machine), infection and inflammatory reaction due to nephrostomy (tube that drains urine from the kidney into a bag) R2's quarterly Minimum Data Set (MDS) dated 9/24, identified R2 did not have cognitive impairment and was not diabetic or insulin dependent. R2's physician orders dated 10/8/24, included:	F 760	correction required.	

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F 760	Continued From page 12 Heparin 5,000 mL injection every 8 hours at 12:00 a.m., 8:00 a.m., and 4:00 p.m. from 10/8/24-10/16/24. R2's progress note dated 10/16/24 at 5:52 p.m. and 5:53 p.m., identified R2 was transferred to emergency department, family, and provider aware. Vital signs (VS) were normal. Normal ranges: oxygen saturation 95-100%, blood pressure 120/80, and pulse 60-100. R2's hospital discharge summary dated 10/17/24, identified reason for admission of iatrogenic hypoglycemia (low blood sugar because of too much insulin) on 10/16/24. On 10/16/24 at 5:37 p.m., emergency medical technicians (EMT) obtained a blood glucose reading of 135. At 5:46 p.m., blood glucose was 98 (normal range 70-110), at arrival to the emergency room blood glucose was 65. R2 received an intramuscular (IM) injection of glucagon (raises blood sugar by causing the body to release sugar stored in the liver) and an amp of D50 glucose which increased the blood glucose reading to 244. On recheck the blood glucose dropped to the 160's and R2 was started on D10 infusion. Poison control was called and informed ED the insulin would peak around 6 hours and recommended R2 continue infusion for at least 6 hours and observe for another 4 hours after that. Glucometer readings from the hospital were: On 10/16/24: -8:16 p.m. 76 -9:18 p.m. 120 -10:46 p.m. 57 On 10/17/24: 6:03 a.m. 226 8:02 a.m. 135 Normal blood glucose ranges from 70-110.	F 760		

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F 760	Continued From page 13 R2's progress note date 10/17/24 at 11:38 a.m., identified R2 returned to facility. During an observation and interview on 10/22/24 at 10:26 a.m., R2 was lying in bed. R2 reported she had gotten insulin instead of heparin on 10/16/24, but was not sure where the insulin came from that was given to her. R2 stated she had to spend the night in the Hospital. R2 stated she felt ok following the incident. During an interview on 10/22/23 at 11:07 a.m., LPN-A stated she worked the floor from 2:00 p.m. to 6:00 p.m. on 10/16/24. At approximately 4:45 p.m., LPN-A could not locate R2's heparin in the med cart. LPN-A searched the medication cart, and reviewed R2's medical chart for verification that the medication was available. LPN-A went to the medication room and looked in the refrigerator and among the insulin pens she saw a vial in a bag. LPN-A removed the bagged vial and misread the label on the bag thinking it read R2's information. LPN-A took a needle and drew from the vial into the needle 100 U of medication, injected the medication into R2's abdomen, and then left the room. LPN-A returned to the medication cart and was going to date the vial she opened. LPN-A noticed the vial was not heparin but insulin, realized the error, and notified case manager (CM)-A. CM-A then called an ambulance and R2 was transferred to the emergency department (ED). LPN-A stated she had never given a resident heparin before and was not aware of what the vial would look like. During an interview on 10/23/24 at 12:14 p.m., CM-A stated on 10/16/24, LPN-A notified her she had given R2 insulin instead of heparin. CM-A	F 760		

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F 760	Continued From page 14 told LPN-A to get a set of VS and she would inform nurse practitioner (NP)-A, who was in the building, of the incident. CM-A went to R2's room to complete an assessment. R2 was alert and orientated, stated she did not want to go to the hospital and was aware of the medication error. CM-A stated that neither she nor LPN-A checked R2's blood glucose reading after the incident. During an interview on 10/23/24 at 2:48 p.m., NP-A stated on 10/16/24 she was at facility when CM-A notified her R2 was given 100 U of insulin and asked if R2 could be sent to the ED. NP-A directed R2 to be sent into the hospital. NP-A stated the medication error would be considered significant in nature and could result in serious harm or death. During a phone interview on 10/23/24 at 10:19 a.m., pharmacist (P)-A stated Fiasp is a quick acting insulin that takes effect 20 minutes after injection. Peak would be 1-3 hours and typically last 3-5 hours. P-A was informed of the amount administered to R2, P-A stated "Yikes, that is a lot of insulin especially for a non-diabetic, even if diabetic that is a lot." During an interview on 10/23/24 at 3:32 p.m., director of nursing (DON) stated with each and every medication the nurse should go through the six rights of medication administration. If LPN-A would have done that the error would not have occurred. DON stated LPN-A was suspended following investigation along with completing re-education with her before returning to the floor, interviewed residents for medication error concerns, provided competency testing, and education for all nurses, replaced the bottle of Fiasp with an insulin pen, removed the vial of	F 760		

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F 760	Continued From page 15 heparin from the medication cart and placed in residents locked cupboard, updated the MAR for licensed staff to write in the lot number and expiration date of all injectable medications, began an auditing system to review with Quality Assurance Performance Improvement. The IJ that started 10/16/24, was removed on 10/17/24, after it was verified the facility implemented the following corrective actions: -LPN-A suspended pending investigation and then completed re-education and competency education on 10/16/24 and 10/17/24. -interviewed residents for any medication error concerns on 10/16/24. -provided education and competency testing on the rights of medication administration to licensed nursing staff 10/17/24 and continuing until all staff complete. -replaced the vial of Fiasp insulin with insulin pen on 10/17/24. -removed the vial of heparin from the medication cart and placed in resident's locked medication cupboard on 10/17/24. -updated procedure for administration of all subcutaneous injections, when signing off in the electronic medication administration record, to include the lot number and expiration date of the medication on 10/17/24. -implemented an auditing system for administration of subcutaneous injections on 10/17/24. The facility Administering Medications policy revised 8/31/23, identified staff to ensure safe administration of resident's medication as indicated and ordered by the provider by following the 6 rights of medication administration:	F 760		

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F 760	Continued From page 16 a. Right resident b. Right medication c. Right dose d. Right time e. Right route f. Right documentation The facilities Medication Error/Occurrence policy revised 8/31/23, identified the licensed nurse to provide immediate care and notification of provider and resident/representative when nursing or medical intervention, observation, or treatment is indicated. The resident condition is assessed including obtaining VS. Action is taken to prevent the error from reoccurring.	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		11/26/24

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F 880	Continued From page 17 conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 18 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review the facility failed to ensure proper handwashing/hand hygiene was implemented for 4 of 9 residents (R8, R7, R9 and R6) observed during a medication pass. In addition, the facility failed to ensure proper cleaning of glucometer for 1 of 3 residents (R6) and failed to utilize enhanced barrier precautions (EBP) for 2 of 2 residents (R1 and R5) during wound dressing changes. Findings include: R8's face sheet dated 10/24/24, identified diagnoses of type 2 diabetes mellitus (condition that affects how the body uses sugar as fuel). During an observation on 10/23/2024 at 7:15 a.m., Licensed practical nurse (LPN)-C entered room for R8. Hand hygiene was not performed prior to entering room. The glucometer was removed from locked medication cabinet, along with strips, alcohol pad, and cotton ball. LPN-C applied gloves without performing hand hygiene, assisted R8 to reposition with same gloved hands, then obtained blood sugar. LPN-C then removed gloves and did not perform hand hygiene prior to leaving R8's room. R7's face sheet dated 10/24/24, identified diagnosis of Type 1 diabetes mellitus (chronic condition that affects the pancreas ability to	F 880	" Enhanced Barrier Precautions initiated for R1 and R5. o Individual Glucometer obtained for R6. o No ill effects noted for R6, R7, R8, and R9 related to missed hand hygiene opportunity. o Care plans reviewed and revised as necessary to include infection prevention and control techniques. " All facility residents with a need for Enhanced Barrier Precautions were reviewed and precautions implemented as necessary. o All facility residents with orders to obtain routine blood glucose readings were given individual glucometers. o Care plans reviewed and revised as necessary to include infection prevention and control techniques. " All licensed nursing staff will be re-educated on Enhanced Barrier Precautions (IP060), Cleaning and Disinfecting Blood Glucose Meter Policy (IP015), and Hand Hygiene Policy (IP054). " • Audits related to infection control practices will be completed three times a week for 4 weeks, then twice weekly for 4 weeks, then once a week for 4 weeks on various shifts and days; Audits to include hand hygiene, glucometer disinfection,	

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F 880	Continued From page 19 produce insulin). During an observation on 10/23/2024 at 7:20 a.m., LPN-C entered R7's room. Hand hygiene was not performed prior to entering room, donned (applied) gloves and took R7's blood sugar. LPN-C removed gloves and did not perform hand hygiene prior to leaving room. R9's face sheet dated 10/24/24, identified diagnoses of systemic lupus erythematosus (autoimmune disease that affects many body systems and causes inflammation, rash, fatigue, and fever). During an observation on 10/23/2024 at 7:40 a.m., LPN-C entered R9's room. Hand hygiene was not performed prior to placing gloves on. A patch was applied to R9's lower back, and ace wraps applied to both legs. LPN-C removed gloves without performing hand hygiene and then pushed R9 to dining room. LPN-C then got coffee and juice for R9 and touched beverage buttons in dining room. R6's face sheet identified diagnosis of Type 2 diabetes mellitus. During an observation on 10/23/2024 8:00a.m., LPN-C removed a glucometer out of the bottom of the medication cart. LPN-C did not perform hand hygiene, donned gloves, and obtained blood sugar for R6. The glucometer was not disinfected and was placed back in the bottom of the cart for universal use. LPN-C removed gloves and did not perform hand hygiene. At 8:15 a.m., LPN-C administered insulin injection without performing hand hygiene before and after.	F 880	and enhanced barrier precautions. 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.	

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	245426	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 20 During an interview on 10/23/24 at 8:30 a.m., LPN-C stated the glucometer in the bottom of the cart is a "universal one and we use this one is just in case the resident does not want to go back to their room." LPN-C stated that every resident had a glucometer in their room, "But this one is for everyone, if needed." LPN-C stated that the glucometer should have been cleaned after use, and that handwashing/hand hygiene should be performed before entering room and leaving room, when hands soiled, in between residents, and before/after glove removal. Per the Centers for Disease Control (CDC) dated 6/28/24: EBP are indicated during high contact care activities for residents with infection or colonization with a CDC targeted multi-drug resistant organisms (MDRO) (when contact precautions do not apply) or for any resident who has a chronic wound and/or indwelling medical device. High-contact resident care activities include dressing, bathing/showering, transferring, toileting, providing hygiene, changing linens or briefs, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care: generally, for residents with a chronic wound(s), not skin breaks or tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing. R5's face sheet dated 10/24/24, identified diagnoses of burn of unspecified degree of left thigh. During an observation on 10/24/24 8:11 a.m., LPN-B performed dressing change to R5's left upper thigh. EBP was not used to perform this	F 880		

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F 880	Continued From page 21 dressing change. No signage instructing staff to use EBP, or supplies noted outside of R5's room. R1's face sheet identified diagnoses of laceration to right lower leg. During an observation on 10/24/24 at 10:38 a.m., LPN-B performed dressing change on R1's right lower leg. EBP was not used to perform this dressing change. No signage instructing staff to use EBP, or supplies noted outside of R1's room. During an observation on 10/24/24 at 12:29 p.m., nurse practitioner (NP)-A, clinical manager (CM)-A, and infection preventionist/wound nurse (IPWN)-A obtained a culture and sensitivity test from R1's laceration on right lower leg and performed wound dressing care. EBP was not used during this dressing change. No signage instructing staff to use EBP was noted outside of R1's room. R1's culture and sensitivity dated 10/27/24, identified results from the laceration to the right shin/calf as 4+ staphylococcus aureus. During an interview on 10/23/24 at 11:40 a.m., the director of nursing (DON) stated the glucometers in the bottom of the medication carts are only to be used for emergency situations and should not be used for individual residents. The glucometer should have been cleaned after use. During an interview on 10/24/24 at 2:16 p.m., IPWN-A stated the glucometers in the bottom of medication cart is for emergency use only, nurses should clean them before and after use. IPWN-A stated hand washing/hand hygiene should be done before and after entering rooms, before and	F 880		

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F 880	Continued From page 22 after touching residents and before applying gloves and after removal. IPWN-A stated the process to determine if residents need EBP, would be to check the CDC grid. IPWN-A stated R1 will be placed on EBP due to having an open wound. During an interview on 10/24/24 at 4:26 p.m., DON stated any resident with an indwelling catheter, chronic wound, wound with significant drainage or open wound should have enhanced barrier precautions. The facility policy on Hand Hygiene review/revision dated 09/23, identified hand hygiene to be performed before and after resident contact, before and after performing invasive procedure (e.g., fingerstick blood sample); Before and after assisting with personal cares and after removing gloves. The facility policy on Resident Care Equipment dated 06/2017, identified that reusable equipment is not used for the care of another resident until it has been cleaned and reprocessed appropriately. It also stated glucometers to be cleaned between residents. The facility policy on Enhanced Barrier Precautions revised on 04/01/24 identified enhanced barrier precautions will be used for any chronic wounds. According to the Centers for Disease Control and Prevention document Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes | LTCFs | CDC: If a resident does not have a history of a Multi Drug Resident Organism (MDRO) and has a wound, they should be placed on Enhanced Barrier Precautions (EBP). who do	F 880		

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F 880	Continued From page 23 not otherwise meet the criteria for Contact Precautions.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 6, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: PUME11

Dear Administrator:

The above facility was surveyed on October 18, 2024 through October 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
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

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 _____	10/24/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/22/24, 10/23/24, and 10/24/24 , 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 orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54269546C (MN00107493), H54269558C (MN00107569), and H54269546C (MN00107635) with licensing orders issued at: 0565, 0830, and 1390 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	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to revise the care plan for 2 of 9 residents reviewed (R1, R5) who had non-pressure related skin injuries. Findings include R1's face sheet dated 10/23/24, identified diagnoses of contusion to the head, fracture of facial bones, laceration without foreign body right lower leg, and nontraumatic subarachnoid hemorrhage. R1's care plan dated 9/16/23, identified R1 was at risk for falls related to history of falls and dependent on staff for transfers and ambulation.	2 565	Corrected	11/26/24

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2 565	Continued From page 3 R1's progress note dated 10/10/24 at 7:04 p.m., identified R1 fell forward out of chair and landed on pavement with wheelchair landing on top of her. Lacerations to forehead, and cheek, bruising and swelling along with bleeding to nose, bleeding noted in mouth, large laceration to right shin/calf. 9-11 called to escort via ambulance to ED for evaluation. The care plan did not identify R1's impaired skin integrity nor a plan of care that included goals and individualized interventions from the fall on 10/10/24. During an interview on 10/23/24 at 8:45a.m., licensed practical nurse (LPN)-B stated R1 does not have a dressing on her leg, the stitches were removed the other day and it was just monitoring the leg. During an observation and interview on 10/24/24 at 10:26 a.m., LPN-B measured the wound to R1's right lower leg at 6.5x2 centimeters (cm). "I am surprised at how open it is after the stitches were removed." "The wound seems like it has some erythema or irritation to it." During an interview on 10/24/24 at 2:14 p.m., Infection Preventionist/Wound Nurse (IPWN)-A expected the floor nurses to notify her of wounds. Nothing was communicated except that R1 had scrapes and bruises. "If someone would have told me she had a wound she would have gotten on my list." IPWN-A updates care plans for wounds that are followed by her. During an interview on 10/24/24 at 12:37 p.m., nurse practitioner (NP)-A stated she was unaware of a thigh wound to R1's right leg. NP-A was aware of the fall but had not followed the wound	2 565		

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2 565	Continued From page 4 care. The facility should have that in the care plan with interventions for staff to follow. R5's face sheet dated 10/24/24, identified diagnoses of surgical after care following surgery on the nervous system, burn of unspecified degree of left thigh, difficulty in walking, and muscle weakness. R5's comprehensive Minimum Data Set (MDS) dated 10/1/24, identified R5 had impairment on both sides of his lower body, and independent with wheelchair mobility. R5 was cognitively intact. R5's care plan dated 10/1/24, identified R5 was at risk for burn from hot liquids related to decreased sensory perception. R5's progress note dated 9/7/24 at 8:55 p.m., identified during weekly skin check R5 had a small red area from pizza burn that measured 0.5 x 0.3 cm. R5's physician encounter dated 9/27/24, identified R5 was seen for evaluation of left thigh burn due to placing hot popcorn directly on his thigh. Nursing had applied kerlix to the burn area. No signs of infection so Silvadene was ordered with kerlix wrap to prevent rubbing. Nursing to continue to check skin daily and current dressing. Burn measured 3.5 x 3.0 cm R5's progress note dated 10/8/24 at 1:38 p.m., identified discussion to ask for help to use microwave to prevent burns and safety. R5's care plan did not include the burns R5 received and the care plan was not revised to include the aforementioned intervention.	2 565		

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2 565	Continued From page 5 During an interview on 10/24/24 at 4:21 p.m., DON would expect the blisters to be in the care plan with interventions "I know it is not in his care plan to bring the popcorn back for him." During an interview on 10/24/24 at 12:37 p.m., NP-A stated she would expect the facility to notify her of all burns that occur. NP-A stated the clinic would follow the wound care if they were aware of it. The facility should have that in the care plan with interventions for staff to follow. The facility Resident/Family Participation in Care Planning policy dated 10/2/23, included: -Residents are informed of their rights and actively participate in person centered care planning per their discretion. -The resident has the right to see the care plan, including the right to sign after changes to it and to receive the services and/or items included in the plan. -The resident has the right to be informed, in advance, of the care to be furnished, the type of care giver or professional that will furnish care, and of changes to the plan of care. -Care conference documentation includes that staff resident and others that participate. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.	2 565		

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2 565	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
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 observation, interview, and record review the facility failed to comprehensively assess, monitor, and notify the physician of wounds for 2 of 3 residents (R1, R5) who had non-pressure related skin injuries. The facility's failures resulted in harm when R1's laceration to her calf became painfully infected which delayed healing, required antibiotics, and ongoing wound management. Findings include R1's face sheet dated 10/23/24, identified diagnoses of contusion to the head (bruise to the brain), fracture (break) of facial bones, laceration	2 830	Corrected	11/26/24

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2 830	Continued From page 7 (cut) without foreign body right lower leg, and nontraumatic subarachnoid hemorrhage (bleeding below the arachnoid layer of the brain). R1's brief interview and staff assessment for mental status (BIMS) dated 7/29/24, identified R1 had severe cognitive issues. R1's care plan dated 9/6/23, identified a potential for impaired skin integrity. Interventions included dressings per wound nurse or as ordered, monitor skin integrity weekly with showers, report to Nurse Practitioner (NP) or Medical Doctor as needed. R1's progress note dated 10/10/24 at 7:04 p.m., identified R1 was outside in the parking for an activity. R1's chair rolled off the curb at approximately 6:30 p.m. R1 fell forward out of chair and landed on pavement with wheelchair landing on top of her. Lacerations to forehead, and cheek, bruising and swelling along with bleeding to nose, bleeding noted in mouth, large laceration to right shin/calf. 9-11 called to escort via ambulance to ED for evaluation. R1's ED visit note dated 10/10/24, identified laceration repair to right calf that was a complex clean 5-centimeter (cm) laceration. 10 milliliters (mL) of lidocaine (numbing agent) injected in skin. Irrigated (rinsed) with normal saline. No debridement (procedure to remove debris from wound) and wound explored, no foreign body found. Wound was closed in one layer. Skin closed with 4-0 ethilon (brand of suture) using interrupted sutures. 4 sutures placed. ED visit notes did not include orders for wound care. R1's progress note dated 10/11/24 at 3:46 p.m., identified R1 returned from hospital with no new	2 830		

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	00644	A. BUILDING: _____ B. WING _____	10/24/2024

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2 830	Continued From page 8 orders and had sutures in lower right leg. R1's progress note dated 10/14/24 at 6:00 a.m., identified wound to right shin/calf stitches remain intact. Area is slightly red around the edges; some scabbing can be seen. No warmth or signs/symptoms of infection currently. R1's physician order dated 10/11/24, identified a physician order to monitor laceration site on right lower leg for wound care once a day for signs/symptoms of infection. Keep covered. Another order dated 10/11/24, identified an order to remove sutures from right lateral calf on 10/21/24. R1's medication administration record (MAR) dated 10/23/24, included a physician order to monitor laceration site on right lower leg wound once a day for signs/symptoms of infection. Keep covered. Beginning 10/11/24-open ended. From 10/12/24-10/23/24, six administrations are marked with an asterisk (charting code that indicated "comment in reasons/comments"). One administration was marked parenthesis (charting code that indicated "not administered or not charted, see reasons/comments.") Review of R1's progress notes did not include further information pertaining to the wound as indicated by the charting codes. In review of R1's record between 10/11/24, the record did not include a comprehensive assessment of the lacertation, nor include documentation indicating the wound was continously monitored for deterioation or improvement, signs/symptoms of infection, and administered treatments. During an interview on 10/23/24 at 8:45a.m.,	2 830		

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2 830	Continued From page 9 licensed practical nurse (LPN)-B stated R1 did not have a dressing on her leg, the stitches were removed the other day and it was just monitoring the leg. During an observation and interview on 10/24/24 at 10:26 a.m., family member (FM)-A went to LPN-B and requested R1's dressing to her right lower leg be changed "it has been on there for a couple of days." R1 was in bed. LPN-B noted the dressing to her leg was not dated. It was an ABD dressing (thick absorbant dressing) with tape holding it in place. LPN-B removed the tape and started to pull off the ABD pad however, the dressing was adhered to the wound. R1 yelled out "ow!" while tape was being removed. LPN-B left room "to get water". R1 stated "I'd like to quit the hurting in my legs." LPN-B returned at 10:45 a.m., LPN-B used normal saline to wet the dressing. R1 continued to yell out "ow!" LPN-B described the drainage as scant and serosanguineous. Granulated blood and scab intact on the other side of the wound. "she had some stitches in it and they are removed now." LPN-B measured the wound 6.5 x 2.0 cm. LPN-B was under the impression that R1 was seen by LPN infection preventionist/wound nurse (IPWN)-A. LPN-B applied a mepilex dressing which did not cover the wound, the adhesive border of the bandage was placed on the scabbed area of the wound. "I am surprised at how open it is after the stitches were removed." "The wound seems like it has some erythema (redness) or irritation to it." LPN-B verified the only order was to monitor the laceration site. During an interview on 10/24/24 at 12:37 p.m., nurse practitioner (NP)-A stated she was unaware of a thigh wound to R1's right leg. NP-A was aware of the fall but has not followed the wound	2 830		

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2 830	Continued From page 10 care. During an observation and interview on 10/24/24 at 1:34 p.m., NP-A, IPWN-A and clinical manager (CM)-A went to R1's room to observe the dressing. NP-A verified the dressing was too small for the wound and was not covering the whole wound. IPWM-A measured the wound at 6.0 x 3.0 cm. NP-A requested staff use Vashe wound wash, siver calcium alginate, mepilex, and get a wound culture for the wound. R1 stated the leg hurt. NP-A stated that it is definitely red around the wound. NP-A explained to IPWN-A the erythema needed to be measured. IPWN-A measured the erythema at 6.0 x 10.0 cm. NP-A explained to IPWN-A and CM-A the wound must be cleaned before obtaining the culture. NP-A used vashe to rinse the wound. NP-A noted a suture was still in the wound. The suture is located between 4 and 5 o'clock. IPWN-A stated if she would have been aware of the wound she would have been following R1. It was her understanding that R1 only had a scrape. IPWN-A stated the floor nurses were able to initiate wound care. NP-A was hesitant to remove the suture as she was unable to find the knot. NP-A obtained the culture, requested a large mepilex be put on the wound, and R1 go to the ED for removal of suture. R1's wound care order dated 10/24/24, identified right lower leg wound dressing once daily. Cleanse the wound with Vashe (wound cleanser that contains pure hypochlorous acid that helps fight bacteria and infection) and pat dry with sterile gauze. Apply a sterile silver calcium alginate (highly absorbent antimicrobial wound dressing that inhibits the growth of microorgansims inside the dressing) to fit the wound bed. Lightly moisten with vashe- do not	2 830		

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2 830	Continued From page 11 saturate. Cover with a mepilex (brand of dressing) foam dressing. R1's culture and sensitivity dated 10/27/24, identified results from the laceration to the right shin/calf as 4+ staphylococcus aureus. Sensitivity to doxycycline was included as <=0.5 S. R1's prescription order dated 10/28/24, identified doxycycline hyclate (antibiotic) capsule 100 milligrams (mg) take 1 capsule twice a day for a total of 20 doses. During an interview on 10/24/24 at 2:14 p.m., IPWN-A stated she was unaware how the floor nurses would notify or document wounds. IPWN-A expected the floor nurses to notify her of wounds. Nothing was communicated except that R1 had scrapes and bruises. R5's face sheet dated 10/24/24, identified diagnoses of surgical after care following surgery on the nervous system, burn of unspecified degree of left thigh, difficulty in walking, and muscle weakness. R5's comprehensive Minimum Data Set (MDS) dated 10/1/24, identified R5 had impairment on both sides of his lower body, and independent with wheelchair mobility. R5 was cognitively intact. R5's care plan dated 10/1/24, identified R5 was at risk for burn from hot liquids related to decreased sensory perception. R5's progress note dated 9/7/24 at 8:55 p.m., identified during weekly skin check R5 had a small red area from pizza burn that measured 0.5 x 0.3 cm.	2 830		

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2 830	Continued From page 12 R5's progress note dated 9/21/24 at 6:28 p.m., identified a pizza burn to right upper thigh that measured 0.5 x 0.3 cm. R5's care plan did not include the burns R5 received, or interventions to prevent burns to body. During an interview on 10/24/24 at 7:46 a.m., nursing assistant (NA)-A stated R5 had a burn on his left upper thigh and a burn on his hand "a while back that is healed that was from pizza." During an observation and interview on 10/24/24 at 7:53 a.m., R5 was in bed. R5 stated he had two burns from pizza one on the right hand and above his watch on his wrist. The facility made the pizza. The pizza fell out of R5's mouth and onto his arm. R5 stated the facility never measured the burns, "the only one that was measured was the popcorn burn." During an observation on 10/24/24 at 8:09 a.m., LPN-B stated the left wrist pizza burn area measured 1.0 x0.7cm and was circular, appearing as a scar. The area between the thumb and pointer finger was resolved. During an interview on 10/24/24 at 10:26 a.m., LPN-B stated R5's pizza burn was on his arm. LPN-B stated he found out about the burn on 9/9/24. LPN-B verified that there was no documentation of the burn except for the progress note. An event should be opened, and orders in the MAR for treatment. LPN-B stated the progress note does not identify when the event occurred, only that it was documented during the weekly skin check on bath day.	2 830		

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2 830	Continued From page 13 During an interview on 10/24/24 at 2:14 p.m., IPWN-A would expect the care plan to be updated with wounds, and wounds must be measured weekly. During an interview on 10/24/24 at 12:37 p.m., NP-A stated she would expect the facility to notify her of all burns that occur. NP-A stated the clinic would follow the wound care if they were aware of it. The facility should have that in the care plan with interventions for staff to follow. During an interview on 10/24/24 at 4:21 p.m., director of nursing (DON) stated the CM should follow any wound the wound nurse is not following. The CM should get weekly measurements and document on wounds. DON was unaware how many sutures were in R1's wound and was unsure if the hospital provided the number of sutures they placed. DON would have expected a progress note identifying how many sutures were removed and the appearance of the wound when the sutures were removed. DON expected the floor nurses to notify the medical provider or IPWN-A of worsening wounds. IPWN-A can activate standing orders for wound care. DON verified IPWN-A was not certified for wound care. DON was not able to articulate education that IPWN-A received at facility but stated IPWN-A was in a wound nurse role at her previous job. DON was unaware of any competencies IPWN-A completed. DON verified medical doctor was at facility and removed two sutures from R1. The facility Prevention and Treatment of Skin Breakdown policy dated 9/1/18, identified skin is observed daily with cares, and weekly by licensed staff. Attending provider, resident and resident representative notified, supervisor, and dietitian	2 830		

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2 830	Continued From page 14 notified. Weekly staging, measuring, and examination of the wound bed and surrounding skin. Notification to provider if deterioration occurred or no change in two weeks. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with impaired skin integrity, to assure they are receiving ongoing monitoring and assessment of the skin along with the necessary treatment/services to promote improvement. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of edema not being cared for properly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;	21390		11/26/24

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21390	Continued From page 15 F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observations, interview, and document review the facility failed to ensure proper handwashing/hand hygiene was implemented for 4 of 9 residents (R8, R7, R9 and R6) observed during a medication pass. In addition, the facility failed to ensure proper cleaning of glucometer for 1 of 3 residents (R6) and failed to utilize enhanced barrier precautions (EBP) for 2 of 2 residents (R1 and R5) during wound dressing changes. Findings include: R8's face sheet dated 10/24/24, identified diagnoses of type 2 diabetes mellitus (condition that affects how the body uses sugar as fuel). During an observation on 10/23/2024 at 7:15 a.m., Licensed practical nurse (LPN)-C entered room for R8. Hand hygiene was not performed prior to entering room. The glucometer was removed from locked medication cabinet, along with strips, alcohol pad, and cotton ball. LPN-C applied gloves without performing hand hygiene, assisted R8 to reposition with same gloved	21390	Corrected	

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21390	Continued From page 16 hands, then obtained blood sugar. LPN-C then removed gloves and did not perform hand hygiene prior to leaving R8's room. R7's face sheet dated 10/24/24, identified diagnosis of Type 1 diabetes mellitus (chronic condition that affects the pancreas ability to produce insulin). During an observation on 10/23/2024 at 7:20 a.m., LPN-C entered R7's room. Hand hygiene was not performed prior to entering room, donned (applied) gloves and took R7's blood sugar. LPN-C removed gloves and did not perform hand hygiene prior to leaving room. R9's face sheet dated 10/24/24, identified diagnoses of systemic lupus erythematosus (autoimmune disease that affects many body systems and causes inflammation, rash, fatigue, and fever). During an observation on 10/23/2024 at 7:40 a.m., LPN-C entered R9's room. Hand hygiene was not performed prior to placing gloves on. A patch was applied to R9's lower back, and ace wraps applied to both legs. LPN-C removed gloves without performing hand hygiene and then pushed R9 to dining room. LPN-C then got coffee and juice for R9 and touched beverage buttons in dining room. R6's face sheet identified diagnosis of Type 2 diabetes mellitus. During an observation on 10/23/2024 8:00a.m., LPN-C removed a glucometer out of the bottom of the medication cart. LPN-C did not perform hand hygiene, donned gloves, and obtained blood sugar for R6. The glucometer was not disinfected	21390		

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21390	Continued From page 17 and was placed back in the bottom of the cart for universal use. LPN-C removed gloves and did not perform hand hygiene. At 8:15 a.m., LPN-C administered insulin injection without performing hand hygiene before and after. During an interview on 10/23/24 at 8:30 a.m., LPN-C stated the glucometer in the bottom of the cart is a "universal one and we use this one is just in case the resident does not want to go back to their room." LPN-C stated that every resident had a glucometer in their room, "But this one is for everyone, if needed." LPN-C stated that the glucometer should have been cleaned after use, and that handwashing/hand hygiene should be performed before entering room and leaving room, when hands soiled, in between residents, and before/after glove removal. Per the Centers for Disease Control (CDC) dated 6/28/24: EBP are indicated during high contact care activities for residents with infection or colonization with a CDC targeted multi-drug resistant organisms (MDRO) (when contact precautions do not apply) or for any resident who has a chronic wound and/or indwelling medical device. High-contact resident care activities include dressing, bathing/showering, transferring, toileting, providing hygiene, changing linens or briefs, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care: generally, for residents with a chronic wound(s), not skin breaks or tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing. R5's face sheet dated 10/24/24, identified diagnoses of burn of unspecified degree of left	21390		

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21390	Continued From page 18 thigh. During an observation on 10/24/24 8:11 a.m., LPN-B performed dressing change to R5's left upper thigh. EBP was not used to perform this dressing change. No signage instructing staff to use EBP, or supplies noted outside of R5's room. R1's face sheet identified diagnoses of laceration to right lower leg. During an observation on 10/24/24 at 10:38 a.m., LPN-B performed dressing change on R1's right lower leg. EBP was not used to perform this dressing change. No signage instructing staff to use EBP, or supplies noted outside of R1's room. During an observation on 10/24/24 at 12:29 p.m., nurse practitioner (NP)-A, clinical manager (CM)-A, and infection preventionist/wound nurse (IPWN)-A obtained a culture and sensitivity test from R1's laceration on right lower leg and performed wound dressing care. EBP was not used during this dressing change. No signage instructing staff to use EBP was noted outside of R1's room. R1's culture and sensitivity dated 10/27/24, identified results from the laceration to the right shin/calf as 4+ staphylococcus aureus. During an interview on 10/23/24 at 11:40 a.m., the director of nursing (DON) stated the glucometers in the bottom of the medication carts are only to be used for emergency situations and should not be used for individual residents. The glucometer should have been cleaned after use. During an interview on 10/24/24 at 2:16 p.m., IPWN-A stated the glucometers in the bottom of	21390		

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21390	Continued From page 19 medication cart is for emergency use only, nurses should clean them before and after use. IPWN-A stated hand washing/hand hygiene should be done before and after entering rooms, before and after touching residents and before applying gloves and after removal. IPWN-A stated the process to determine if residents need EBP, would be to check the CDC grid. IPWN-A stated R1 will be placed on EBP due to having an open wound. During an interview on 10/24/24 at 4:26 p.m., DON stated any resident with an indwelling catheter, chronic wound, wound with significant drainage or open wound should have enhanced barrier precautions. The facility policy on Hand Hygiene review/revision dated 09/23, identified hand hygiene to be performed before and after resident contact, before and after performing invasive procedure (e.g., fingerstick blood sample); Before and after assisting with personal cares and after removing gloves. The facility policy on Resident Care Equipment dated 06/2017, identified that reusable equipment is not used for the care of another resident until it has been cleaned and reprocessed appropriately. It also stated glucometers to be cleaned between residents. The facility policy on Enhanced Barrier Precautions revised on 04/01/24 identified enhanced barrier precautions will be used for any chronic wounds. According to the Centers for Disease Control and Prevention document Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes | LTCFs | CDC: If a resident does not have a	21390		

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	00644	A. BUILDING: _____ B. WING _____	10/24/2024

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
21390	Continued From page 20 history of a Multi Drug Resident Organism (MDRO) and has a wound, they should be placed on Enhanced Barrier Precautions (EBP). who do not otherwise meet the criteria for Contact Precautions. SUGGESTED METHOD OF CORRECTION: The infection preventionist (IP) could develop additional infection control surveillance, teaching and methods to mitigate the risk of infections spreading. IP could ensure all staff are trained on the importance of PPE, hand hygiene with enteric precautions, cleaning equipment, handrails, and carts with commercial wipes and following dwell time of these products. Teach and provide surveillance when staff feeding a resident and when they remove pitchers/glasses from an isolation room to fill with water/ice. Audits could be done to ensure that hand hygiene and other infection control practices are routinely followed during cares, cleaning equipment, handling ice and feeding a resident to maintain a clean environment. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		