

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/28/2024
NAME OF PROVIDER OR SUPPLIER  Koda Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30th Street NW Owatonna, MN 55060	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49616</p> <p>Based on observation, interview, and document review the facility failed to revise the care plan for 1 of 4 residents (R1) observed who were identified to have behavioral issues not addressed in the care plan.</p> <p>Findings include</p> <p>R1's Continuity of Care Document (CCD) dated 6/27/24, identified an admitted [DATE]. Medical diagnoses included anxiety disorder, dementia (deterioration of memory, language, and other thinking abilities), restless leg syndrome (overwhelming urge to move legs, usually associated with unpleasant sensations often during sleep and relieved by movement), pain, arthritis (condition that affects the joints causing pain, stiffness, and reduced movement), abnormalities of gait and mobility, history of falling, and weakness.</p> <p>R1's Behavior Observation assessment (annual) dated 3/20/24, identified a section titled 'Other behavior symptoms not directed toward others' and to note presence of symptoms and frequency. The assessment indicated R1's behaviors included disrobing in public and the behavior occurred one to three days in the last seven days. The assessment identified that this behavior intruded on the privacy and activity of others and remained unchanged from prior assessments. Action taken to continue current plan of care.</p> <p>R1's Minimum Data Set (MDS) Quarterly review dated 3/20/2024, identified severe cognitive impairment. MDS failed to identify R1 wandered (moves with no rational purpose, seemingly oblivious to needs or safety). R1 was independent with transfers and wheelchair use.</p> <p>R1's care plan edited on 3/20/24, identified R1 exhibited wandering and wandered to other units and front door. R1 wandered into other resident rooms and had a history of using the bathroom in inappropriate places. Interventions included R1 to have supervision when ambulating off the unit, redirection when wandering in others rooms, attempt to redirect back to unit if R1 walked off unit.</p> <p>Although the Behavior Observation assessment dated [DATE], identified R1 demonstrated disrobing in public behaviors the care plan was not revised to include the behavior(s).</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility reported incident (FRI) submitted to the State Agency (SA on 6/22/24 included staff noticed R1 in a male residents room with door was closed. Staff found R1 standing next to her wheelchair with her pants and brief down and near her knees. R1's care plan was not revised after the incident to include the behavior of disrobing until 6/27/24.</p> <p>R1's care plan was revised on 6/27/24, to include that R1 would occasionally remove clothing at inappropriate times and in appropriate places. No goal or interventions to manage the behavior were included.</p> <p>During an interview on 6/26/24 at 12:27 p.m., nursing assistant (NA)-A stated R1 did not always understand what staff say to her. She wandered frequently and went into other resident rooms and laid in their beds. NA-A stated R1 had been in seven or eight rooms that morning. with R1 it is a thing for her to strip naked and walk the halls.</p> <p>During an interview on 6/26/24 at 1:18 p.m., NA-B stated R1 liked to strip and walk down the hall, it was mainly bottoms down, but not the top, she did it a lot. NA-B stated there was no direction given on how to divert or stop it from happening. Nothing has been put in the care plan for us and no one had directly told us anything about that. Miscommunication happens a lot.</p> <p>During an interview on 6/26/24 at 1:43 p.m., licensed practical nurse (LPN)-A stated R1 strips bottom half down anytime of the day. R1 typically would strip in her room and then go into the hallway.</p> <p>During an interview on 6/26/24 at 3:19 p.m., NA-D stated R1 strips her bottom half down most commonly in her room and then goes in the hallway. NA-D stated that one time she found her in the kitchen stripped.</p> <p>During an interview on 6/26/24 at 3:26 p.m., NA-E stated that he has always seen R1 have her clothes off in her room and he would go in and redress her. NA-E stated that there was no direction given on how to proceed if R1 was unclothed in the hall.</p> <p>During an interview on 6/27/24 at 2:04 p.m., clinical manager (CM)-A stated unfortunately R1 did have a history of taking her clothes off anywhere, and frequently removed them. Recently she took them off at the dining room table. R1's family was aware of it, and they have brought in different textures of clothes and CM-A indicated she did not think that the texture or the size of the clothing was a factor in R1 removing her clothes. CM-A recommended redirection, aiding, and to keep R1 in eyesight as able to prevent the behavior. CM-A was not aware if the care plan had interventions in place for R1 disrobing.</p> <p>During an interview on 6/28/24 at 10:15 a.m., with Regional Director of Clinical Services-South Region (RDCS), Director of Nursing (DON) and Administrator were present. DON stated there was not a specific assessment for wandering in rooms and undressing. DON explained it was common for R1 to wander due to her cognition level and her care was updated on 6/27/24 to include removal of clothing at inappropriate times and places. DON stated assessments were completed, and care plans created so staff have appropriate interventions to maintain safety and continuity of care.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facilities Comprehensive Assessments and Care Planning policy revision dated 9/27/23, identified that to provide a comprehensive person-centered interdisciplinary care assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental and psychological functioning possible, a facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State.</p> <p>7. a facility should use the results of the assessment to develop, review and revise the resident's person-centered comprehensive care plan.</p> <p>8. assessment process must include direct observation and communication with resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This includes nursing assistant assigned to the resident and culinary staff.</p>