

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  07/24/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42355</p> <p>Based on observation, interview and document review, the facility failed to ensure the administrative staff and State Agency (SA) were notified immediately but no later than 2 hours of an allegation of neglect for 1 of 1 resident R1 who fell from a mechanical lift.</p> <p>Findings include:</p> <p>A facility reported incident was submitted to the state agency (SA) on 7/22/24, at 1:34 p.m. The incident report identified R1 experienced fall during transfer from chair to bed.</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had intact cognition, with diagnoses of muscle weakness. R1 was dependent on staff for transfers, took anticoagulants and had no history of falls.</p> <p>R1's progress note dated 7/21/24 at 9:40 p.m., indicated R1 had a fall from a mechanical lift the resulted in skin tears to her right index and middle fingers and left bicep area.</p> <p>During an interview on 7/24/24 at 1:01 p.m., director of nursing (DON) indicated that she was made aware of R1's fall that had occurred on 7/21/24 on 7/22/24 at 8:03 a.m. DON stated it was her expectation that any fall with injury or fall from mechanical lift was reported to her or the on-call nurse, provider, and family members immediately but no later than 2 hours.</p> <p>Review of the facility's policy dated indicated:</p> <p>9. Reporting of Suspected Resident Abuse and/or Neglect</p> <p>a. Staff will notify the facility Charge of Building immediately of any reports of possible abuse, neglect, misappropriation of resident property, and/or financial exploitation. The Charge of Building will immediately notify the Executive Director or designee in the ED's absence.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. The community is responsible for reporting suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation in accordance with legal requirements. If the event that caused the suspicion involves abuse or results in serious bodily injury, the individual is required to report the suspicion immediately, but not later than 2 hours after forming the suspicion. If the event does not involve abuse and does not result in bodily injury, the individual is required to report no later than 24 hours after forming the suspicion.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42355</p> <p>Based on interview and document review the facility failed to safely use a mechanical lift per manufactures recommendations to transfer 1 of 1 resident (R1), who required a mechanical lift for transfers. This resulted in an immediate jeopardy (IJ) when R1 fell from a full body mechanical lift causing R1 to sustain a fractured sternum and left pelvic hematoma that required a hospital admission and blood transfusion.</p> <p>The IJ began on 7/21/24 at 9:40 p.m., when staff failed to ensure lift sling was properly secured prior to the transfer causing R1 to fall from the mechanical lift. The administrator, regional nurse manager, and director of nursing (DON) were notified of the IJ on 7/24/24 at 4:13 p.m. The IJ was removed on 7/22/24, when the facility implemented immediate corrective action before survey to prevent recurrence, therefore, the IJ was issued at past non-compliance.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1' had intact cognition R1 used a motorized wheelchair, was dependent with all transfers, and did not walk. R1 took anticoagulants (blood thinners).</p> <p>R1's mobility care plan dated 3/27/24, directed staff to transfer R1 with a full body mechanical lift (hoyer-brand name) using a medium sized sling and two staff. indicated transfers with hoyer lift.</p> <p>R1's progress note dated 7/21/24 at 9:40 p.m., indicated licensed practical nurse (LPN)-A was called to room by nursing assistants (NA)s. When nurse entered room R1 was laying on the floor beside the bed. R1 stated she did not hit her head. R1 was assisted with hoyer lift to bed. NA-B and NA-S stated R1 was hooked up and lifted per protocols During the transfer R1 fell to the floor in the sling. NA-B and NA-S unaware what caused sling to fall. The note indicated R1 sustained skin tears to right index and middle finger that were covered with band aids, a skin tear with bruising to left bicep that measured 8.0 centimeters (cm) x 8.0 cm which was covered with a dressing, and bruising to the top of left shoulder. R1 declined being examined in the emergency department (ED).</p> <p>R1's progress note dated 7/22/24 at 1:55 a.m., indicated R1 was reporting total body pain post fall and pain in upper left thigh that had light blue bruising, was slightly swollen and tender to touch. R1 requested and was given acetaminophen (Tylenol) 650 milligrams (mg) approximately 1:40 a.m.</p> <p>R1's progress note dated 7/22/24 at 3:34 a.m., R1 reported her neck and right side of her head hurt, no redness, swelling, bruising or any signs of injury. R1 declined to go to emergency department for further evaluation, ice pack was applied to right side of her head and neck.</p> <p>R1's progress note dated 7/22/24 at 8:33 a.m, indicated R1 was transferred to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's hospital records indicated on 7/22/24, R1 presented to a local emergency room however was then air lifted to a higher level hospital for further trauma evaluation. Records indicated R1 had concerning blood pressure of 68 with a repeat of 79/43 (normal is 110/70). Imaging identified R1 had acute to subacute nondisplaced transverse fracture of the manubrium (sternum) and a large left hip hematoma measuring 20.6 centimeters (cm) x 8.8 cm x 5.3 cm. Additionally, was given a diagnosis of anemia with a hemoglobin of 6.3 grams/deciliter (normal is for females is 12-16 g/dl) secondary to hemorrhage that required a blood transfusion.</p> <p>During an interview on 7/24/24 at 8:37 a.m., family member (FM)-B stated R1 remained in the intensive care unit (ICU). R1 remains in the hospital.</p> <p>During an interview on 7/23/24, (NA)-B indicated on 7/21/24 around 9:30 p.m. she was working with NA-S when R1 fell from the lift when they were transferring R1 off of the commode. NA-B indicated she was running the controls of the lift; she lifted R1 up into air off the commode. While R1 was suspended in the air NA-S performed peri-care. NA-B then started to push the lift towards R1's bed, that was when the upper right sling strap came off the hook of the lift and R1 fell approximately three feet to the floor. LPN-C was notified via radio of the fall. LPN-C arrived to the room and completed assessments. R1 sustained skin tears and complained of pain in both her shoulders. R1 was transferred off the floor to her bed using the same lift and sling she had just fallen from. LPN-C applied dressings to the wound and R1 was given ice packs for pain. NA-B indicated NA's had checked and confirmed they both used the same color sling straps were connected to the lift, however, could not articulate they had checked the tension of the straps once R1 was lifted up and prior to the transfer. NA-B stated she had received education on following the manufacturer's instructions after the incident.</p> <p>During an interview on 7/24/24 at 12:50 p.m., NA-S stated she was working with NA-B on 7/21/24. They were transferring R1 from the commode to the bed when the top right strap came off the lift causing R1 to fall to the floor. NA-B called LPN-C on the radio, while NA-S stayed with R1. NA-S stated she did not know how the loop came off the lift. NA-S explained they had checked to ensure the same color straps were used however, did not articulate the placement and/or tension were checked after R1 was raised in the air and prior to the transfer to ensure the straps did not loosen or move. NA-S stated she had received education on how to complete safe lift transfers after R1's fall.</p> <p>During an interview on 7/24/24 at 12:05 p.m., LPN-A stated on 7/21/24 at 9:40 p.m., she was called to R1's room as R1 fell from a mechanical lift and was on the floor. LPN-A did an assessment of R1 prior to moving her, skin tears to right index and middle finger and able to move all major joints. LPN-A, NA-B and NA-S used the same sling and lift to get R1 off the floor and into bed. Once in bed staff noticed bruising and a skin tear to the left bicep. LPN-A indicated R1 refused to go to the hospital on her shift, however, was sent in on 7/22/24. LPN-A further stated since the incident, the procedure was to report falls from lifts immediately to the on-call nurse, DON, administrator as well as the provider immediately. LPN-A stated she received education on safe lift transfers following R1's fall.</p> <p>Review of the facility's smart lift safety and maintenance checklist for the lifts dated 7/22/24 indicated that both lifts were inspected by maintenance per protocol, with no issues noted. Inspection of the slings were also completed, no frays or other damage was noted.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/24 at 1:01 p.m., director of nursing (DON) explained the lift and sling that was involved in the incident were inspected, there were no issues found with either. The fall was likely a result of operator error because there were no issues found with the equipment. DON stated it was her expectation for staff to follow manufactures recommendations when using mechanical lifts. Equipment that is involved in accidents needs to be removed from operation and checked by Maintance to ensure the lift/lift accessories are safe to use. DON indicated all nursing staff were re-educated with return demonstration on using the mechanical lifts on 7/22/24.</p> <p>During an interview on 7/24/24 at 11:50 a.m., lift representative (LR)-A stated staff were to remove the lift and the lift sling from operation until maintenance can perform preventative maintenance per manufacture recommendations. LR-A explained staff needed to check the tension of the sling loops/straps by touching each one to make sure they are secured onto the lift. This check is completed while the resident is being lifted and still on/over the surface that they are being raised off of.</p> <p>The immediate jeopardy that started on 7/21/24, was removed on 7/22/24 after it was verified the facility implemented the following corrective actions:</p> <ul style="list-style-type: none"> <li>-On 7/22/24 the facility implemented re-education that included return demonstration to all nursing staff per the manufacture's recommendations prior to working the floor.</li> <li>-On 7/22/24 maintenance inspected all the lifts for function and safety. Additionally checked the slings for any issues.</li> <li>-Residents who used mechanical lifts were all reassessed to ensure proper sling size and confirmed accuracy of care plans by 7/22/24</li> <li>-Facility contacted the manufacturer for additional in person re-iteration of training on 7/25/24</li> <li>-On 7/22/24, the facility revised policy/procedure to include that all falls are reported to the nurse on call, provider, and family of significant falls, even when resident ask staff to not notify.</li> <li>-On 7/22/24, the facility revised their post fall follow up to include documentation and monitoring guidelines, anticoagulation, vital sign and assessment with neuro checks if hit head.</li> </ul> <p>EZ-Way Smart Lift Operator Manual included the following:</p> <ul style="list-style-type: none"> <li>-the EZ Way Smart Lift was designed to lift patient/resdient's from bed, chair, toilet and floor.</li> <li>-all washable EZ Way slings are capable of bearing a 1,000 pounds weight load, but must only be used to hold the amount of weight dictated by the EZ Way Smart Lift capacity.</li> <li>-do not modify the sling design in any way, make the accessories used with each lift are appropriate for both the patient and the transferring situation.</li> <li>-all EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided.</li> </ul> <p>(continued on next page)</p>		

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