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	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Koda Living Community	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 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 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. (continued on next page)

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

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER: Koda Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 2255 30th Street NW Owatonna, MN 55060	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 [DATE], 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. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49616 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. 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. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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 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 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 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and record 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 ,d+[DATE], identified R2 did not have cognitive impairment and was not diabetic or insulin dependent. R2's physician orders dated 10/8/24, included: 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 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-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. 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 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. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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: a. Right resident b. Right medication c. Right dose d. Right time e. Right route f. Right documentation (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49616 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 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. (continued on next page)

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER: Koda Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 2255 30th Street NW Owatonna, MN 55060	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 not otherwise meet the criteria for Contact Precautions.