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	07/09/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure safe transfers with a full body mechanical lift for 1 of 3 residents (R1) reviewed for falls/safety. This resulted in actual harm when R1 fell from the lift, had severe back pain, and needed to be sent to the emergency department (ED) for evaluation. The facility implemented immediate corrective action, so the deficient practice was issued at past non-compliance.Findings include:R1's face sheet dated 7/9/25, identified diagnoses of paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), acquired absence of left leg above the knee, and burst fracture of the T11-T12 vertebrae (a serious spinal injury when the vertebra breaks). R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was dependent on staff for all transfers and cognitively intact. R1 had no falls since previous assessment.R1's Safe Lifting and Movement assessment dated [DATE], identified R1 had an amputation, paraplegia, and required two persons transfer using a full mechanical lift.R1's mobility focus care plan dated 10/13/20, identified R1 had limited ability to transfer self, related to lower body paraplegia. Interventions included: assist of two with total mechanical lift and large amputee sling. R1's fall focus care plan dated 9/14/20, identified R1 was at risk for recurrent falls related to lower body paraplegia, left leg above the knee amputation (AKA), and use of total mechanical lift for transfers. Interventions included: R1 needed an large amputee sling, two staff for all mechanical lift transfers, and remind resident not to lean forward during total mechanical lift transfers.R1' s fall event dated 6/25/25 at 3:00 p.m., identified R1 had a witnessed fall from the total mechanical lift) while being transferred from wheelchair to bed. R1 stated he fell out of the total mechanical lift. R1 complained of severe pain all over. Immediate intervention of assist of three for all total mechanical lift transfers was put into place. Review of R1 care plan identified revision on 6/25/25 to reflect the aforementioned intervention. R1's progress note dated 6/25/25 at 3:34 p.m., identified R1 found lying on the floor on his back with his head towards the wall. R1 was being transferred with the total mechanical lift into bed and the sling slipped out of the lift and resident landed on the floor. R1 was assisted back into bed and was then sent by emergency management services (EMS) for evaluation. R1's emergency department (ED) notes dated 6/25/25, identified R1 was seen in the ED for evaluation after a fall from elevation when lift strap broke causing patient to slide down onto floor, hit back of his head and left side. R1 noted pain in the back of head and had tenderness along midline thoracic spine. Computed tomography (CT) of brain, abdomen, pelvis, and cervical spine did not identify any hemorrhage or fractures. R1 was discharged back to the skilled nursing facility. R1's progress note dated 6/25/25 at 6:55 p. m., identified R1 returned from ED with no new orders and no fractures from the fall.R1's progress note dated 6/26/25 at 1:53 a.m., R1 reporting during repositioning he was in pain, particularly his chronic pain was bothering him. R1 rated pain six out of ten in a pain scale and was given an as needed pain medication. R1's medication administration record (MAR) identified on 6/26/25 R1 received a one dose of opioid narcotic pain medication and had not received any dose since 6/13/25. R1's progress note dated 6/26/25, identified a fall screen was completed by occupational therapy and recommended physical therapy (PT) for transfers, positioning, and bed mobility.R1's progress note dated 6/30/25, identified R1 had a PT evaluation completed and R1 would benefit from ongoing services for range of motion and low chronic back pain. R1 and spouse declined PT at this time. Additionally recommend wheelchair assessment for positioning, pressure offloading, and ease of mechanical lift transfers (i.e., reclining wheelchair), however, R1 and spouse declined, stating he is happy with current wheelchair. Recommended returning to assist of two staff for mechanical lift for all transfers. During an interview on 7/9/25 at 11:40 a.m., physical therapist (PT)-G stated she performed R1 evaluation on 6/30/25 and did not observe any concern during the transfer. R1 did not have any shift of weight and had proper body positioning during the transfer. The correct size sling was being used and did not feel the need to have three staff were needed for the transfer, therefore she recommended to return to assist of two for all transfers with the total mechanical lift.R1's interdisciplinary team (IDT) note dated 7/1/25, identified the IDT team met to discuss R1's fall on 6/25/25. R1 was being transferred from wheelchair to bed when he fell from the total mechanical lift sling. R1 had been slowly rotated at the same time he was being lifted from the chair when family member (FM)-A began removing his wheelchair from underneath R1. Staff and FM-A reported R1 was 10-12 inches above his wheelchair seat when he fell, landing on the edge of the wheelchair and slid down to the foot pedal. R1 complained of increased neck and back pain and had three abrasions on left elbow. R1 was transferred to the ED for evaluation and found to have no fractures. Root