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	12/11/2025

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review the facility failed to ensure there was a communication process between the long-term care (LTC) facility and the hospice provider to ensure the needs of the resident are addressed and met 24 hours per day for 1 of 1 resident (R2) reviewed for hospice services.Findings include:R2's face sheet dated 10/31/25, identified diagnoses of heart failure (a condition where the body's heart does not pump enough blood for the body's needs), atrial fibrillation(a common heart rhythm disorder), and anxiety disorder (a mental health condition defined by excessive worry and fear).R2's admission Minimum Data Set, dated [DATE], identified R2 was dependent for all transfers, received hospice services, and was cognitively intact. R2's hospice focus care plan dated 8/14/25, identified R2 received hospice services with a goal of preferred wishes for end of life to be honored. Interventions were as follows: facility will coordinate with hospice providers and reference hospice care plan located in hospice binder; see hospice care plan for resident choices and preferences related to comfort, cognition, pain, and functional status.During an interview on 10/31/25 at 8:45 a.m., licensed practical nurse (LPN)-B stated R2's hospice binder kept in the nursing station, however, did not contain a hospice care plan, visit schedule, or any notes kept in the binder. LPN-B stated when R2's hospice nurse comes to visit R2 in the facility they do not communicate with the nursing staff to let them know what was done during the visit or if any of the care had changed and this seems to be a constant problem. During an interview on 10/31/25 at 8:51 a.m., LPN-A stated R2's hospice binder did not contain a current hospice care plan, nurse/aide visit schedule, nor any documentation of the nursing visits. LPN-A further stated this information should be located in the binder, so staff are aware of what cares is supposed to be done for any hospice resident. During an interview on 10/31/25 at 2:38 p.m., registered nurse (RN)-A stated she is the contact person for hospice agencies and had not been getting consistent communication from R2's hospice agency and she was unaware the R2's hospice binder did not contain a care plan nor a visit schedule. During an interview on 10/31/25 at 3:54 p.m., hospice registered nurse clinical manager (H-RNCM) stated, R2's hospice care plan had been sent to the facility on 8/24/25 but had not verified that it was received by the facility. Weekly/Monthly nurse/aide hospice visit schedules should have also been provided to the facility and she was unaware the facility had not been receiving this information. H-RNNM further stated that hospice staff should be completing documentation in the note section of the binder and also communicate with the nursing staff after each visit to discuss if any changes to the plan of care. During an interview on 10/31/25 at 3:36 p.m., director of nursing (DON) stated R2's hospice plan of care had not been added to the hospice binder nor the electronic health record and this should have been added to ensure that collaboration of care was done with R2's hospice. DON further stated the facility had not been getting informed consistently following visits from R2's hospice nurse.Review of the facility's Nursing Home Hospice Agreement dated 8/15/13, indicated hospice will document in the facility chart any assessments and care provided to the patient and will communicate verbally as well with each visit to facility staff the results of its visit. The facility staff will receive Hospice's 24-hour phone line number to report any needs or concerns when hospice staff are not present in the facility. Review of the facility's Hospice Policy undated, identified the community will provide collaborative care with hospice providers to ensure the resident's end of life preferences and choices are honored. The policy's procedures were as followed: -There is a designate a member of the community's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the community associates and hospice staff; The designated interdisciplinary team member is responsible for: -collaborating with the hospice representatives and coordinating community associate's participation in the hospice care planning process for those residents receiving these services. -Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family.- Ensuring that the community communicates with the hospice medical director, theresident's attending provider, and other practitioners participating in the provision of care.to the resident as needed to coordinate the hospice care with the medical care provided byother physicians. Obtain the following information from hospice:i. The most recent hospice plan of careii. Hospice election formiii. Physician certification and recertification of the terminal illness specific to eachresidentiv. Names and contact information for hospice personnel involved in hospice care ofeach residentv. Emergency instructions on how to access hospice's 24-hour on-call system vi.