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	07/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 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 observation and interview, the facility failed to ensure care was provided in a dignified manner for 1 of 2 residents (R24) reviewed for dignity, when the resident was left in bed, unclothed. Findings include:R24's face sheet provided on 7/24/25, included diagnoses of hemiplegia (weakness or partial paralysis on one side of the body) following a stroke.R24's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R24 had moderately impaired cognition, clear speech, could understand and be understood. R24 required partial or substantial assistance with activities of daily living and did not walk. R24's physician order dated 7/3/24, indicated to apply barrier cream to penis and scrotum daily, 6:30 a.m. - 11:00 a.m.R24's care plan with revised date of 7/10/25, indicated R24 needed assistance with dressing, personal hygiene, and bathing due to decline in mobility related to but not limited to hemiplegia.During an interview on 7/21/25 at 3:52 p.m., R24 stated that morning an agency nursing assistant (NA) got him up to dress. R24 stated he didn't know the name of the NA and she wasn't wearing a name tag. R24 stated that was the first time he had seen her, and she didn't seem to know what to do. R24 stated he had a very detailed morning routine where a NA dressed him halfway, then a nurse came in and put cream on his skin, then the NA returned to finish dressing him. That morning, R24 stated the NA came into his room and started cleaning him up. Then the NA informed R24 he had better find someone else to do the job and left the room. R24 stated there had been another NA across the room with his roommate so he called out and asked her if someone else could finish with him. R24 stated, I didn't like it - I don't know where they got her from - she didn't know anything. The director of nursing (DON) was asked on 7/22/25 at 4:27 p.m., who had been assigned to care for R24 and his roommate the morning of 7/21/25. The DON indicated NA-D had been assigned to R24, and NA-E had been assigned to his roommate. During an interview on 7/23/25 at 11:13 a.m., NA-E recalled the events of 7/21/25, when she was working with R24's roommate. NA-E stated NA-D was a brand-new NA with no prior experience who was afraid to do anything with residents. NA-E stated R24 had called out to her to come to his side of the room. Immediately NA-E observed R24 in bed with his shorts down and his brief open with his genitals exposed. NA-E stated she covered R24 right away and finished his cares and reported the incident to the licensed practical nurse (LPN)-C on duty. NA-E stated she did not know where NA-D went when she left R24's room. Neither LPN-C nor NA-D were available for interview.During an interview on 7/23/25 at 12:20 p.m., registered nurse (RN)-C who was also the clinical manager for the unit on which R24 resided, stated she was unaware of the situation that occurred on 7/21/25, with R24 and NA-D. During an interview on 7/24/25 at 12:00 p.m., the DON stated she learned of the 7/21/25, incident with R24 from her staff on 7/23/25. The DON stated she was informed NA-D had left R24 in his bed with his brief open, door open, curtain open and window blinds open. The DON stated she was informed that NA-E covered R24 and reported it to LPN-C who did not report it to nursing leadership, telling the DON he didn't think of it. The DON stated LPN-C was removed from the schedule pending investigation and in addition, the DON had not been able to reach NA-D for interview. The DON stated the incident was reported to the State Agency on 7/23/25. The DON stated she would have expected LPN-C to report the incident to a nurse leader right away. The DON stated licensed staff had training on reporting incidents involving concerns of resident dignity. The DON stated NA-D was a new employee who had completed orientation the week prior. The DON stated she was aware of training concerns and registered nurse (RN)-B, who was also the staff development nurse, had talked to NA-D on 7/16/25, about adding more orientation days. NA-D's new hire competency checklist was reviewed which indicated NA-D had received training on values including respect - acknowledges resident dignity in carrying out duties dated 7/16/25. NA-D had received training on personal care on7/16/25, and perineal care on 7/17/25.Facility Resident Rights and Notification of Resident Rights policy with revised date of 1/16/24, indicated the purpose was to provide for prompt notification of resident rights. The facility acted to protect and ensure the rights of residents.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews the facility failed to provide a method for residents and resident representatives to submit grievances anonymously. In addition the facility failed to follow their grievance process for missing/damaged personal property for 1 of 1 resident (R69) who reported a missing item. This had the potential to prevent all 72 residents in the facility.Findings include: On 7/23/25 at 11:20 a.m., during resident council R2, R25, R26, R29, R45, R52, R55, R61, R63, R64, R69, R74, R75, R78 each stated that they were unaware of any method to submit concerns anonymously and stated that no anonymous grievance process had been made known to them. On 7/23/25 at 3:00 p.m., during a facility tour, social services (SS)-A confirmed there was no grievance box or any other designated area for anonymous grievance submission accessible to residents available in resident accessible locations. Further, no signage or posted information indicated an option for submitting concerns confidentially or anonymously. On 7/24/25 at 11:58 a.m., the administrator confirmed the facility did not currently have a grievance box and stated residents could place the concern form under the door of SS-A. During a tour of the Dawn Wing, an acrylic wall mount containing a binder with concern forms was observed high on the wall. The administrator acknowledged that the location of the binder would be difficult for residents to reach independently. Facility Policy titled Concerns, Grievances dated 6/29/22, indicated: Purpose: To create an environment where resident and customer concerns are solicited and readily resolved. Policy: I. A resident/customer/resident representative has the right to voice grievances and concerns without discrimination or reprisal and without fear of discrimination or reprisal. II. The term “voice concerns” is not limited to a formal, written grievance process, but may include a resident’s verbalized concerns to staff. Concerns and grievances can be made anonymously. III. The community views customer concerns as a primary method to learn of and meet customer expectations. In keeping with this belief, staff is trained to obtain and respond to resident/resident representative customer concerns. When a resident, resident representative, visitor or family member voices a concern to a staff member, the staff member completes a concern form and forwards the form to the Social Services department/Grievance Officer /designee in a confidential container. II. Completed forms are processed in a timely manner (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The social worker/grievance officer /designee checks the confidential container daily; removes the completed forms, logs the concern, and routes the copy to the staff responsible to acknowledge, investigate, and resolve the concern. MISSING ITEM R69’s face sheet printed 7/24/25, indicated diagnoses of chronic pain, restless leg syndrome, muscle weakness, and type two diabetes mellitus. R69’s care plan revised 7/10/25, indicated R69 enjoyed being busy and needed invitations and escorts to activities of interest. R69’s goal was to express satisfaction with daily routine and leisure activities. R69’s quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition and no behaviors or rejection of care. During interview on 7/21/25 at 4:12 p.m., R69 stated she had been missing a windchime with cats on it. R69 further stated it had gone missing when she moved from one neighborhood to another neighborhood within the facility back in December 2024. R69 stated activity assistant (AA)-A helped her move and knew about the missing item. During interview on 7/23/25 at 11:02 a.m., AA-A stated she clearly remembered helping R69 move to her new room and reporting R69’s missing windchime to her supervisor. AA-A further stated she put the windchime in R69’s nightstand for the weekend and when she came back the next week, it was gone. R69 stated she did not know if the facility had a form to fill out for missing items or if there was a grievance form, and she thought when she told her supervisor it would be taken care of by management. During interview on 7/23/25 at 11:15 a.m., wellness director stated she did not recall being told about missing items by AA-A, but recalled being told about some of R69’s broken figurines, which also occurred during the move to the new neighborhood. Wellness director stated she told social services (SS)-A about the broken items but did not follow-up with him to see if an investigation was started and had not heard any more about it since then. During interview on 7/23/25 at 11:22 a.m., SS-A stated he did not know anything about R69’s missing or damaged items. During interview on 7/23/25 at 11:45 a.m., administrator stated wellness director must have forgotten to tell SS-A about the missing items, therefore the concern was not handled. Administrator further stated the missing and damaged items should have been reported to SS-A, a customer concern filled out, and an investigation into the missing and damaged items completed. Administrator stated the facility would speak to R69 about it today. Facility Missing Items policy dated 4/2012, directed; All personnel are responsible for reporting missing items to supervisor staff prior to the end of their shift. Staff works to locate the missing items. If missing item is not located within a 4-hour window, a customer concern is initiated.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified on the Minimum Data Set (MDS) assessment for 1 of 1 resident (R26) reviewed for mood and behaviors, specifically post traumatic stress disorder (PTSD). Findings include: R26's face sheet printed 7/24/25, indicated diagnoses of major depressive disorder and post traumatic stress disorder.R26's care plan revised 7/10/25, indicated the potential for trauma responses related to military service in Vietnam, as evidenced by anxiety around fireworks and being around other people. Interventions included ensuring clear paths to doors if resident was in a room with multiple people and honoring wishes regarding position of entry door.R26's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no behaviors, and lacked a diagnosis for post traumatic stress disorder.During observation on 7/23/25 at 10:00 a.m., R26 was observed entering chapel A for a dietary meeting. Activity Assistant (AA)-A directed R26 to sit near the door to ensure an escape route based on his care plan interventions.During interview on 7/24/25 at 11:08 a.m., registered nurse (RN)-D, also identified as clinical reimbursement manager, confirmed R26 had an active problem in the last 60 day visit note from the provider. RN-D indicated it had to be on the most current provider note or it doesn't get marked on the MDS. RN-D further stated there was a care plan with active interventions in place for R26. During interview on 7/24/25 at 12:45 p.m., administrator stated she thought they had worked with the clinical team last year to make sure only documented active cases of post traumatic stress disorder were marked on the MDS and she would have to look at that again.Facility Comprehensive Assessments and Care Planning policy dated 8/2019, directed: The assessment must accurately reflect the resident's status, and each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure that medications were administered in accordance with accepted professional standards and failed to disinfect the rubber septum of an insulin pen with an alcohol wipe prior to attaching the needle and administering insulin for 1 of 1 resident (R87) observed during insulin administration. Findings include: R87's face sheet printed 7/24/25, indicated R87 was admitted on [DATE], and diagnosis included type 2 diabetes.R87's care plan dated 7/22/25, indicated alteration in nutrition/hydration related to diabetes and obesity and medications reviewed quarterly and prn (as needed). R87's medication administration history dated 7/1/25-7/24/25, indicated Novolog Flex Pen U-100 Insulin; insulin pen; per sliding scale.On 7/22/25 at 12:30 p.m., licensed practical nurse (LPN)-A was observed preparing to administer a subcutaneous insulin injection to R87 using a prefilled insulin pen. LPN-A removed the pen cap and immediately attached the needle without disinfecting the rubber septum with an alcohol wipe. LPN-A then proceeded to prime the pen and inject the insulin into R87's abdomen.On 7/22/25 at 12:33 p.m., LPN-A confirmed the insulin pen was the same pen R87 used each day and confirmed the rubber top of the pen was expected wiped with alcohol prior to attaching the needle and administering insulin. On 7/23/25 at 3:33 p.m., the director of nursing (DON) confirmed the rubber septum of an insulin pen is to be disinfected with an alcohol wipe prior to attaching a new needle and administering each dose.Facility Safe Injection Practice dated 9/23, indicated:Purpose: Injection safety, or safe injection practices, is a set of measures taken to perform injections in an optimally safe manner for the residents and healthcare associates.Policy: It is the policy. to educate and ensure compliance of associates in regards to safe injection practices.Disinfect the rubber stopper of medication vials and the neck of glass ampules with sterile 70% alcohol before inserting a needle or breaking the ampule.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 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 1 of 1 resident (R54) brief was changed according to his care plan, and who was reviewed for activities of daily living (ADLs).Findings include:R54's face sheet provided on 7/24/25, included diagnoses of dementia and Alzheimer's disease. R54's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R54 had moderately impaired cognition, clear speech, could understand and be understood. R54 was always incontinent of bowel and bladder and was dependent upon staff for toileting. R54 did not walk. R54's care plan with edited date of 7/10/25, indicated R54 had urinary incontinence. Care plan approach with edited date of 6/2/25, indicated R54 was on a toileting plan; to check and change brief with AM (morning) and HS (evening), before and after meals and activities and per resident or family request and PRN (as needed). Every Shift: Day 06:00 AM - 02:00 PM, Evening 02:00 PM - 10:30 PM, Night 10:30 PM - 06:00 AM. Care plan dated 4/7/25, indicated camera in use, R54's family had installed a camera in his room. Care plan dated 6/27/25, indicated R54 had impaired bed mobility and required assistance with turning and repositioning related to decreased strength, decreased endurance, impaired range of motion, and cognitive deficit.R54's care sheet (a paper document used by nursing assistants (NA's) to provide them with brief and specific information about residents) undated, indicated to check and change R54's brief with AM and HS cares, before and after meals and activities, per resident or family request and PRN.Documentation of a facility grievance dated 7/5/25, indicated family member (FM)-B expressed concern about R54 being left in wet briefs for extended periods of time. Registered nurse (RN)-E who was also the clinical manager, was assigned to the grievance. Resolution indicated R54 wore high absorbency briefs and was not on a routine toileting schedule. Grievance also indicated a discussion was held with FM-B regarding toileting preferences and R54's care plan was updated to reflect wishes. During an interview on 7/22/25 at 12:51 p.m., FM-B and FM-C both expressed concern about R54 being left in wet briefs for long periods of time. They were aware of this because they placed a Ring camera in R54's room, which the facility was aware of, and FM-B and FM-C monitored. FM-B and FM-C provided documentation of dates and times R54's briefs were changed from 6/29/25, to 7/4/25. The data was obtained from watching the Ring camera in R54's room. FM-B stated she also filed a grievance but did not hear back from anyone. Ring camera footage according to FM-B and FM-C indicated: 6/29/25: R54's brief was changed seven times. Longest period between changes was 5.5 hours. This occurred twice. 6/30/25: R54's brief was changed five times. The longest period between changes was seven hours and 45 minutes. 7/1/25: R54's brief was changed six times. The longest period between one change and 5.5 hours between another. 7/2/25: R54's brief was changed seven times. The longest period between changes was four hours and 15 minutes. 7/3/25: R54's brief was changed four times. The longest period between changes was eight + hours. 7/4/25: R54's brief was changed seven times. The longest period between changes was four hours. During an interview and observation on 7/24/25 at 11:34 a.m., in R54's room, nursing assistant (NA)-C stated R54's brief should be changed every two or three hours and documented on a clipboard located on the wall in R54's room. The form on the clipboard was titled Toileting Schedule. It had 14 columns for dates and 24 rows for times from 7:00 a.m., to 6:00 a.m. The form indicated R54 was to be toileted every 2-3 hours and PRN. The form had many missing entries and was only initialed by staff 25 times. There was no consistency to documenting when R54 had been checked and/or changed. The form also indicated R54 had not been checked and changed every 2-3 hours. The first date on the form was 6/21 with the following dates after that: 6/23, 7/1, 7/10, 7/15, 7/17, 7/24. NA-C stated she could only speak to when she changed R54 and that was every two to three hours. NA-C stated the clipboard was the only place she documented changing R54's brief. At the bottom of the form in small print was: Continue to add BMs (bowel movement) in POC (Point of Care was where NA's documented in the electronic medical record [EMR]).During an interview on 7/24/25 at 12:26 p.m., RN-E was aware of the grievance filed by FM-B about R54 being left in wet briefs for long periods. RN-E stated R54 should be checked and changed roughly every two to three hours - as listed on his care plan. RN-E was asked to provide documentation R54 was being checked and changed at those time intervals. RN-E was also asked to provide documentation that RN-E followed up with FM-B regarding her grievance dated 7/7/25. RN-E was not able to provide documentation for either.During an interview on 7/23/25, at 6:04 p.m., FM-B and FM-C stated emails had been sent to RN-E regarding their concerns about R54 being left wet for extended periods of time and they had shown some of the Ring camera footage to the

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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. (continued on next page)

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F 0684 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 observation, interview and document review, the facility failed to implement a process to ensure that the resident received their scheduled insulin dose while out of the facility for 1 of 1 resident (R90) reviewed for medication administration.Findings include:R90's admission Minimum Data Set Assessment (MDS) assessment dated [DATE], indicated R90 was admitted [DATE], cognitively intact, required supervision with personal hygiene, sit to stand, toilet transfer, utilized a walker and wheelchair, diagnoses included: diabetes, seizure disorder and anxiety.R90's care plan dated 7/24/25, indicated R90 receives an insulin that places them at risk as a high risk medication, monitor for signs and symptoms of hyperglycemia and hypoglycemia; visual impairment related to cataracts as evidenced by difficulty reading fine print writing, legally blind in my left eye, provide large print reading materials or talking books as needed; alteration in nutrition/hydration related to DM (diabetes mellites), anxiety, pain, diet as ordered, encourage consistent meal intakes, avoid skipping meals and high concentrated sweetsR90's Medication Administration Record (MAR) dated 7/1/25-7/23/25, indicatedaccu check four times a day 8:00 a.m., 12:00 p.m., 5:00 p.m., 8:00 p.m.insulin aspart U-100 insulin pen; 100 unit/mL (milliliter) 8 units; subcutaneous three times a day; 8:00 a.m., 12:00 p.m., and 5:00 p.m.,insulin aspart U-100 insulin pen subcutaneous three times a day 8:00 a.m., 12:00 p.m., and 5:00 p.m., Amount to Administer: Per Sliding Scale:If Blood Sugar is 140 to 179, give 2 Units.If Blood Sugar is 180 to 219, give 4 Units.If Blood Sugar is 220 to 259, give 6 Units.If Blood Sugar is 260 to 299, give 8 Units.If Blood Sugar is 300 to 339, give 10 Units.If Blood Sugar is 340 to 379, give 12 Units.If Blood Sugar is 380 to 399, give 13 Units.If Blood Sugar is greater than 400, call MD.R90's MAR documentation indicated, 7/22/25 at 12:00 p.m., LPN-A indicated Blood sugar 2027/22/25 at 12:44 p.m., insulin pen; 100 units, administer 8 units; subcutaneous; LPN-A documented comment indicated: not administered: resident left for home, no insulin given.7/22/25 at 12:44 p.m., insulin pen; 100-unit amount to administer: Per Sliding; LPN-A documented comment indicated: not administered: resident left for home, no insulin given.Review of R90's progress notes and nursing documentation failed to indicate that an alternative plan was in place for administration while R90 was out of the facility.On 7/22/25 at 12:21 p.m., R90's family member presented to the facility and informed LPN-A R90 would be leaving the facility for awhile and would return later. LPN-A was observed to check R90's blood sugar and was 202. LPN-A informed R90, she was not going to administer the insulin due to her not eating and leaving the facility. LPN-A instructed R90 to take insulin when she was at home and ate, R90 stated she was not going to take insulin at home, and LPN-A stated, your blood sugar is kind of high. R90 was observed to leave her room in a wheelchair with FM-A.On 7/22/25 at 12:38 p.m., LPN-A stated R90 had been a diabetic for a long time and would expect her to know her insulin sliding scale, expect her to have insulin at home and would assume she would know the amount and how to administer the insulin. LPN-A further stated she did not know for sure if R90 knew her insulin dose or if she had insulin at home and confirmed R90 was not asked that information. LPN-A stated R90 had been diabetic for so long R90 knew what to do.On 7/23/25 at 7:43 a.m., registered nurse (RN)-A, known as the case manager, stated the facility process for when a resident was out of the facility and had insulin administration was to send the insulin pen, copy of orders, and ensure the resident and/or family were educated prior to the resident leaving the facility.On 7/23/25 at 10:37 a.m., R90 stated when she left the faciity on 7/22/25, with FM-A she did not take any insulin as she did not know the dose she was currently getting at the facility, R90 stated her dose has changed since admitted to the facility and did not eat until returning the facility.On 7/23/25 at 3:33 p.m., the director of nursing (DON) confirmed R90 would not be expected to administer insulin that she had at home, stated would expect the nurse to send the medication, copy of the orders, insulin pen, needle and alcohol and educate resident and family of the medication orders prior to leaving the facility. Facility Out-On-Pass Medications/Leave of Absence policy dated 12/17, indicated:The charge nurse on duty assures that residents have their necessary medications before leaving the facility on pass or therapeutic leave of absence.ProceduresA. When receiving a physician's order for a resident to go out on pass, the charge nurse on duty reviews the resident's medication orders and directions for use with the physician and determines if pass medications are needed. It may be possible to alter administration times to eliminate the need for leave of absence medications if the resident's physician concurs and gives an order to do so. The physician's order should list the medications to be dispensed for the leave of absence, including controlled substances B. The nurse should determine the total number of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Koda Living Community	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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and document review, the facility failed to ensure that the posted nurse staffing information accurately reflected the actual number of nursing assistants (NA) and the total number of hours worked for posted schedules. This had potential to affect all 74 residents or visitors who wished to review the information.Findings include: On 7/22/25 at 1:28 p.m., the posted nurse staffing information was observed posted in the hallway across from the main reception area. The posted information included shift, category of shift, shift times scheduled and staffing hours. 10 CNAs scheduled from 6:00 a.m. to 2:00 p.m. with 65 staffing hours, and1 CNA from 6:00 a.m. to 12:30 p.m. with 6 hours, totaling 81 hoursThe actual staffing schedule for 7/22/25, reviewed concurrently, indicated:1 CNA from 7:55 a.m. to 2:00 p.m. (7 hours and 5 minutes), and8 CNAs from 6:00 a.m. to 2:00 p.m. (72 hours total),Resulting in 79 hours and 5 minutes, not the 81 hours posted.On 7/22/25 at 1:58 p.m., the staffing hours posted was observed with the director of nursing (DON) and the DON further confirmed the posted nurse staffing information lacked accurate data to reflect the total number and actual hours today (7/22/25) of nine NA's not ten.On 7/23/25 at 8:07 a.m., the staffing coordinator (SC-B) stated she had posted the staffing hours on 7/22/25, and confirmed that the data was not updated to reflect staff call-outs or last-minute changes, leading to discrepancies between the actual and posted staffing hours.Facility Posting of Nursing Hours policy dated 9/20/22, indicated :Purpose: To provide the number of direct care associates available during any given shift.Policy: On a daily basis for each shift, the number of nursing associates responsible for providing directcare to the residents is posted. Procedure1. At the beginning of each shift, the number of Licensed Nurses (RN's, LPN's, and LVN's) and the number of unlicensed nursing associates (CNA's) directly responsible for resident care will be posted in a prominent location that is accessible to residents and visitors and is in a clear and readable format. Schedule will be amended as schedule changes.2. Shift staffing information will be recorded for each shift. The information includes:a) The facility nameb) The date for which the information is postedc) The resident census at the beginning of the shift for which the information is postedd) Twenty-four (24) - hour shift schedule operated by the communitye) The shift for which the information is postedf) Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shiftg) The actual time worked during that shift for each category and type of nursing staffh) Total number of licensed and non-licensed nursing staff working for the posted shift3. Records of the posted information are kept on file at the community for 18 months

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure an insulin pen included resident name and dated when opened for 1 of 1 resident (R87) reviewed for medication administration. Findings include: R87's face sheet printed 7/24/25 indicated R87 was admitted on [DATE], and diagnosis included type 2 diabetes.R87's care plan dated 7/22/25, indicated alteration in nutrition/hydration related to diabetes and obesity and medications reviewed quarterly and prn (as needed). R87's medication administration history dated 7/1/25-7/24/25, indicated Novolog Flex Pen U-100 Insulin; insulin pen; per sliding scale three times a day before meals and Toujeo Solostar; 50 units; subcutaneous at bedtime.On 7/22/25 at 12:30 p.m., during observation of medication administration, licensed practical nurse (LPN)-A was observed entering R87's room and unlocking the medication cabinet. LPN-A removed a NovoLog FlexPen insulin pen from the cabinet, attached a needle, primed the pen with two units, dialed to nine units, and administered the insulin to R87's lower abdomen. The NovoLog insulin pen in use had a manufacturer label that included an E-Kit sticker and a blank space for the resident name, which had not been filled in. Additionally, there was no date written on the pen to indicate when it had been opened. LPN-A confirmed during the observation that the insulin pen had been removed from the facility's emergency kit (E-Kit) and acknowledged that the resident name and date opened should have been documented on the pen label, but were not. Further inspection of the medication cabinet revealed a second insulin pen (Toujeo Solostar) that also lacked documentation of the date it was opened. The pen was labeled with the resident's name but did not include date opened information. LPN-A stated insulin pens were expected labeled with both the resident's name and the date the medication was opened.On 7/23/25 at 7:43 a.m., registered nurse (RN)-C, case manager, stated insulin pens were expected labeled with resident identifiers including name and were also expected labeled with open date.On 7/23/25 at 3:33 p.m., director of nursing (DON) stated when a insulin pen was removed from the E-kit the nurse was expected to label the pen with resident name and open date.Facility Safe Injection Practice policy dated 9/23, indicatedInsulin Pens:1. Provide training and oversight on the use of insulin pens to assure competency and use ofproper infection prevention practices.2. Dedicate insulin pens for use with only one resident.3. Do not use unassigned or unlabeled insulin pens.4. Affix resident label directly to the insulin pen.5. Label the pen only, not the outer bag, which could contain an incorrect pen

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure proper food temperatures and provide attractive food in order to ensure palatability for 15 of 15 residents (R2, R25, R26, R29, R45, R52, R55, R61, R63, R64, R69, R74, R75, R78, and R90) reviewed for concerns of cold food. In addition, the facility failed to provide palatable food for 4 of 4 residents (R22, R25, R47 and R78) reviewed for dining. This had the potential to affect all residents who ate food provided by the facility. Finding include: R2's significant change in status Minimum Data Set Assessment (MDS) dated [DATE], indicated severe cognitive impairment. R25's quarterly MDS dated [DATE], indicated severe cognitive impairment. R26's quarterly MDS dated [DATE], indicated cognitively intact. R29's quarterly MDS dated [DATE], indicated cognitively intact. R45's comprehensive MDS dated [DATE], indicated cognitively intact. R52's comprehensive MDS dated [DATE], indicated cognitively intact. R55's quarterly MDS dated [DATE], indicated severe cognitive impairment. R61's quarterly MDS dated [DATE], indicated cognitively intact. R63's quarterly MDS dated [DATE], indicated severe impairment. R64's quarterly MDS dated [DATE], indicated cognitively intact. R69's quarterly MDS dated [DATE], indicated cognitively intact. R74's admission MDS dated [DATE], indicated cognitively intact. R75's annual MDS dated [DATE], indicated cognitively intact. R78's quarterly MDS dated [DATE], indicated severe impairment. R90’s admission MDS dated [DATE], indicated cognitively intact. During interview on 7/21/25 at 3:17 p.m., R26 stated he was part of the facility food committee. R26 further stated residents made several suggestions for food improvement and staff did not do anything about it. R26 stated food had no flavor, was cold and sometimes even frozen. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview and observation on 7/21/25 at 6:23 p.m., R26 had a plate with sweet potato fries on his table in his room. R26 picked up a sweet potato fry and demonstrated it was weak and limp by showing how it fell apart in his fingers. R26 stated the sweet potato fries were cold when served to him and he was not going to eat them. R26 stated food was cold all the time and he did not eat most of it. On 7/21/25 at 3:45 p.m., R90 stated she ate her meals in her room per her preference and consistently received cold food. R90 reported that the macaroni and cheese was repeatedly delivered cold and was not enjoyable. On 7/21/25 at 5:08 p.m., dietary aide (DA)-A removed food from a thermal cart in the Kindle Wing and placed items in the steamer. DA-A took the temperature of the sweet potato fries, at 138 degrees Fahrenheit (F), and the grilled ham and cheese sandwiches, at 140 degrees. DA-A stated the sweet potato fries and sandwiches would be returned to the kitchen for reheating since the food was under 145 degrees. On 7/21/25 at 5:17 p.m., culinary supervisor (CS)-D stated that staff took food temperatures before leaving the kitchen and stated that some foods were known not to hold temperature well. On 7/21/25 at 5:24 p.m., DA-A returned to the Kindle Unit with a thermal cart and removed the reheated sweet potato fries and grilled ham and cheese sandwiches. DA-A took the temperature of the fries, which registered 151°F, and the sandwiches, which registered 173°F. DA-A plated and served the residents in the Kindle dining room. On 7/21/25 at 5:40 p.m., R90’s meal tray was plated and was delivered to her room and meal included tomato soup, a grilled ham and cheese sandwich, sweet potato fries, and coleslaw. R90 stated that the fries were not warm and were cold and would not eat the fries because they were cold. On 7/21/25 At 5:44 p.m., a resident meal tray meal tray containing sweet potato fries and a grilled ham and cheese sandwich was prepared for delivery to a resident. CS-D removed a fry from the plate and stated it did not feel warm. CS-D took the temperature of the fries, which measured 107°F, and confirmed the fries were not warm. CS-D stated that sweet potato fries were a difficult food item to keep warm. On 7/23/25 at 11:12 a.m., during a resident council group interview, 14residents (R2, R25, R26, R29, R45, R52, R55, R61, R63, R64, R69, R74, R75, and R78) consistently reported receiving cold food, food that did not match the menu, and food that lacked taste and appeal. R26 stated the group had discussed food concerns for six months during council meetings and had not seen any results. R64 described the food as “awful.” R63 stated the menu listed “chicken and dumplings,” but the facility served chicken without dumplings. R26, R61, and R64 stated that the grilled ham and cheese sandwiches served on 7/21/25 were so hard they could not be eaten, and the cake served on 7/22/25 was frozen. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The residents expressed frustration that they often had to request alternative meals because the food they originally received was either cold or incorrect and agreed it would be preferable to receive the correct, warm food on the first attempt. The residents stated that staff acknowledged their complaints with comments such as “you’re right, the food is cold,” and were stated education to the staff would be provided, residents stated no improvement had occurred. On 7/23/25 at 2:36 p.m., social services (SS)-A confirmed that residents routinely voiced food concerns during resident council meetings. SS-A stated the resident's complaints were documented on a spreadsheet and forwarded the food concerns to the culinary director. SS-A confirmed that management was aware of the issues but stated the facility lacked the bandwidth. SS-A reported that the facility had formed a Dining Experience Committee to address ongoing complaints, but no measurable improvements or data had been observed. Resident concern report form provided on 7/22/25, indicated the following: 7/16/25, R2 stated the country fried steak was burnt and tough to eat. 6/28/25, R9, R25, R26, R29, R48, R63, R64, and R74, food was undercooked, served cold, and not what was ordered. Food served late. FOOD TEMPERATURE LOG During observation and interview on 7/23/25 at 11:30 a.m., DA-B was observed taking temperatures of chicken, potatoes, vegetables, gravy, and rice as they were pulled from a standing warmer in the kitchen. [NAME] (C)-A was observed writing down temperatures on a document titled Food Temperature Log. Review of the log showed no documented cooking temperatures for the above foods. DA-B and C-A stated they did not know if there was a formal procedure for taking temperatures of foods, they sometimes temped food when it came out of the oven, sometimes when it came out of the warmer, and sometimes both. C-B stated it should be temped when it comes out of the oven to ensure proper safe cooking temperatures. During interview on 7/23/25 at 11:33 a.m., CS-D stated DA-B and C-A should have taken the temperature of the food when it came out of the oven, rather than when it came out of the warmer. CS-D stated she was new to the facility and not sure on a formal procedure for food temperatures. During interview on 7/23/25 at 11:35 a.m., culinary services director (CS)-F stated staff should take food temperatures when the food comes out of the oven, and that temperature should be logged on the Food Temperature Log. CS-F further stated he could not say for sure that the staff knew the process and the staff could use some education on proper procedure for food temping. CS-F further stated there had been a lot of food concerns related to timing of meals, appearance of food, and temperatures of food. CS-F stated they started a food committee and audits to work on problems but confirmed little improvement since April. CS-F stated the sandwiches served on 7/21/25, were not up to expectations, did not appear appetizing, and the menu should have been followed. CS-F further stated he was not aware of any formal culinary education but had been completing as-needed education with dietary staff. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 7/24/25 at 9:45 a.m., administrator stated there had been a lot of food concerns. Administrator further stated they had been working on timing of meals and temperature of food. Administrator stated there had been concerns with presentation and appearance of food and they were aware through the dining experience meetings. Administrator agreed sandwiches on 7/21/25, were not appetizing or made as directed by the recipe. Administrator further stated education was provided to culinary staff on 7/21/25. During interview on 7/24/25 at 1:29 p.m., facility dietician stated she was not aware of the food concerns at the facility and her role was more clinical. Dietician further stated she would expect the recipes to be followed and was not aware culinary staff were not following provided recipes. Dietician stated she would expect staff to cook foods to proper temperatures and document the cooking temperatures, rather than the holding temperatures. Dietician reviewed the facility provided Food Temperature Log for 7/25, and stated the form needed to be updated for ease of understanding and accurate temperatures for food safety. Review of facility documents titled Meeting minutes for dining experience committee dated 2/6/25 through 6/25/25, indicated ongoing problems with food concerns. Notes from meetings included the following: 2/6/25: concerns with food temperature, consistency of times of food service, soggy food, and overcooked desserts. 4/17/25: concerns with food temperature, potatoes not cooked through 3 times, poor food quality, approval requested and received for a pizza oven, pot pies not cooked through, and lack of consistent serving times. 5/28/25: room trays with cold food, late delivery of meals, melted ice cream on trays, serving time consistency. 6/25/25: quality of ham and cheese sandwiches, some are rock hard and some are not cooked, fries not getting crispy, serving time consistency. During observation of facility dining experience committee meeting on 7/23/25 at 10:00 a.m., concerns included food temperature, consistency of serving times, soggy foods, appearance of food, and lack of pizza oven being ordered although it had been approved in April 2025. Review of facility training documents printed 7/24/25, indicated culinary staff were trained in two online courses: Culinary 4U Course and Dining, Nutrition, and Food Safety for New Hires. PALATABLE FOOD R22's quarterly MDS assessment dated [DATE], indicated cognitively intact. R25's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition. R47's quarterly MDS assessment dated [DATE], indicated severe cognitive impairment. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R78's quarterly MDS assessment dated [DATE], indicated a BIMS (brief interview for mental status) score of 00 (as a result of declining the assessment). The dinner menu for 7/21/25, indicated grilled ham and American cheese sandwiches. During meal service observation on 7/21/25 at 5:07 p.m., DA-C brought food from the main kitchen to the kitchenette on the Dawn Unit via a small thermal cart on wheels. During an observation and interview on 7/21/25 at 5:36 p.m., CSA-C removed whole sandwiches from the thermal cart and plated them. Nursing assistants (NA) delivered the plates to residents seated in the dining room. During an observation and interview on 7/21/25 at 5:42 p.m., R22 stated, Look at this – the ham is paper thin as he removed the top slice of bread from his sandwich to view the inside. On the bread were two very thinly sliced pieces of deli ham on top of either butter or a pale-yellow cheese spread. No slice of cheese was visible on the sandwich. R25 spoke up and stated the same thing. In addition, the sandwiches had not been grilled nor where they golden brown in color. CSD-F was asked to look at the sandwiches that both R22 and R25 received. CSD-F was asked if that was the way the sandwiches were supposed to have been made. Culinary Services Director (CSD)-F stated there should have been a slice of cheese on the sandwich. CSD-F stated there were recipes for each of the meals served to residents and he would look to see how the sandwiches were supposed to have been made. At 5:50 p.m., while seated at a dining table, R47 stated his sandwich was, Skimpy with the meat. During an observation and interview on 7/21/25 at 5:55 p.m., licensed practical nurse (LPN)-B walked into the dining area from a resident's room with a tray of untouched food. R78 told her the sandwich was not acceptable and to take it back to the kitchen. During an interview on 7/21/25 at 6:04 p.m., CSD-F presented the weekly menu which indicated residents were supposed to have received ham and American cheese grilled sandwiches. CSD-F stated the sandwiches should have had a slice of cheese on them and should have been grilled. CSD-F provided the paper recipe for the sandwiches which indicated: place one slice of cheese and two ounces of ham between two slices of bread. Brush sandwiches with butter. [NAME] sandwiches on a flat top on both sides until golden brown and the cheese melts. During an observation and interview on 7/21/25 at 6:42 p.m., together with the administrator and CSD-F, looked at R78's sandwich that he did not eat, along with the weekly menu and recipe for the sandwiches. The administrator stated, the sandwiches did not look like they were grilled and admitted the cheese and ham were very small portions. The administrator stated she would also have expected the sandwiches to be cut in half for the residents. During an interview on 7/23/25 at 7:37 a.m., R78 stated the ham and cheese sandwich served to him for dinner on 7/21/25, was not grilled, barely had any meat, and the cheese looked like the kind you would get at a gas station machine. During an interview on 7/23/25 at 8:01 a.m., CSD-F stated one cook made the sandwiches on 7/21/25, and another cook baked them rather than grilling them on the flat top. This cook told CSD-F that he did not have time to grill them on the flat top. CSD-F stated he reviewed with both cooks how the sandwiches should have been made. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility Food Production Methods and Standards policy dated 2012, indicated the following: Foods will be prepared to meet the individual nutritional and therapeutic needs of the residents. Foods will be prepared in a manner to retain nutritive value, enhance flavor and appearance and promote food consumption. The Culinary Services Director is responsible for directing the Culinary Services personnel in proper food preparation and monitoring the food preparation process to promote the highest quality food production and service. The Culinary Services Director is responsible for proper food preparation which includes the following: following the written menu, food preparation according to the standardized recipes in sufficient quantities using correct methods, tasting all foods prior to service, assuring foods are of appropriate quality, food temperature appropriateness at cooking, holding, and service, monitoring for high standards of food preparation in flavor, appearance, and nutrition. Facility Food Production Methods and Standards policy dated 2012, indicated the following: Foods will be prepared to meet the individual nutritional and therapeutic needs of the residents. Foods will be prepared in a manner to retain nutritive value, enhance flavor and appearance and promote food consumption. The Culinary Services Director is responsible for directing the Culinary Services personnel in proper food preparation and monitoring the food preparation process to promote the highest quality food production and service. The Culinary Services Director is responsible for proper food preparation which includes the following: following the written menu, food preparation according to the standardized recipes in sufficient quantities using correct methods, tasting all foods prior to service, assuring foods are of appropriate quality, food temperature appropriateness at cooking, holding, and service, monitoring for high standards of food preparation in flavor, appearance, and nutrition.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure appropriate treatment and services for a Foley catheter for 1 of 1 resident (R11) reviewed for catheter cares. In addition, the facility failed to follow proper infection control practices for 1 of 1 resident (R54) observed during peri care. Findings include: FOLEY CATHETER CARE R11's face sheet printed 7/24/25, included diagnosis of acute kidney failure, and obstructive and reflux uropathy (blockage in urinary system) and benign prostatic hyperplasia (enlarged prostrate) with lower urinary tract symptoms. R11's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R11 had moderately impaired cognition, was dependent on staff for bathing, toileting, dressing and transfers and R11 had a Foley catheter. R9's care plan dated 7/11/25, identified R11 had a indwelling Foley catheter with interventions including keep catheter tubing free of kinks, keep drainage bag below bladder level, maintain a closed catheter drainage system, and secure catheter tubing to upper leg to prevent catheter being pulled out. On observation 7/21/2025 7:00 p.m., an unidentified staff was exiting the room and R11 was in his recliner chair with urinary drainage bag lying on the floor. On observation on 7/22/25, at 1:28 p.m. R11 was in his recliner chair with the catheter bag lying on the floor next to the chair. R11 stated the catheter is always laying on the floor. On interview 7/23/25 at 12:46 p.m., nursing assistant (NA)-A stated she has found the catheter bag laying on the floor many times, but she always ensures it is hooked to the material on the side of the chair. NA-A added the catheter bag should not be on the floor. On interview 7/24/25 at 11:40 a.m., registered nurse (RN)-A stated the catheter back should be hooked up to whatever is available and off the floor below the level of the bladder. On interview 7/24/25 at 11:49 a.m., the director of nursing (DON) stated the catheter bag should be hooked so the bag is not on the floor below the level of the bladder. The DON confirmed the catheter bag should not be on the floor. On interview 7/24/25 at 11:52 a.m., RN-B, also identified as infection prevention nurse stated the catheter bag should not be on the floor. A request for Catheter Care was requested but none was received. PERI-CARE (continued on next page)

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	07/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's face sheet provided on 7/24/25, included diagnoses of dementia and Alzheimer's disease. R54's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R54 had moderately impaired cognition, clear speech, could understand and be understood. R54 was always incontinent of bowel and bladder and was dependent upon staff for toileting. R54's care plan with edited date of 7/10/25, indicated R54 had urinary incontinence. Care plan approach with edited date of 6/2/25, indicated R54 was on a toileting plan; to check and change brief with AM (morning) and HS (evening), before and after meals and activities and per resident or family request and PRN (as needed). During observation and interview on 7/24/25 at 11:34 a.m., while changing R54's brief and providing peri-care, observed nursing assistant (NA)-C wipe around R54's genitals with a wet washcloth, then set the washcloth on R54's overbed table. R54's overbed table had personal items on it including his water mug, telephone and was where he ate his meals. NA-C did this twice with two separate washcloths. NA-C initially stated she placed the soiled washcloths on the edge of the wastebasket when done with them and when informed of the observation of her placing them on the overbed table, then stated she set the soiled washcloths on top of a strip of plastic garbage bag that was still folded. NA-C admitted the strip of plastic would not provide adequate coverage to protect the surface of the overbed table from being contaminated by two soiled washcloths. During an interview on 7/24/25 at 12:49 p.m., the director of nursing (DON) was informed of the observation of a NA placing soiled washcloths on a strip of a plastic bag on R54’s overbed table. The DON stated that was not acceptable at any time, and especially since that was where R54 ate his meals. Facility Activities of Daily Living policy dated 6/2021, indicated residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility.