DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1YC7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00751

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245519**

2.STATE VENDOR OR MEDICAID NO.
(L2) **883417100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COURAGE KENNY REHABILITATION INSTITUTE'S TRP**
(L4) **3915 GOLDEN VALLEY ROAD**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/01/2013**

6. DATE OF SURVEY **11/28/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, Unit Supervisor 11/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 12/13/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/16/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245519
December 13, 2016

Ms. Marcia Lindig, Administrator
Courage Kenny Rehabilitation Institute's Transitional Rehabilitation Program
3915 Golden Valley Road
Golden Valley, MN 55422

Dear Ms. Lindig:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 15, 2016 the above facility is certified for or recommended for:

48 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 48 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 13, 2016

Ms. Marcia Lindig, Administrator
Courage Kenny Rehabilitation Institute's Transitional Rehabilitation Program
3915 Golden Valley Road
Golden Valley, MN 55422

RE: Project Number S5519027

Dear Ms. Lindig:

On October 24, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 6, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 6, 2016, effective November 15, 2016 and therefore remedies outlined in our letter to you dated October 24, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245519 Y1	A. Building B. Wing Y2	11/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE KENNY REHABILITATION INSTITUTE'S TRP	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0242	Correction	ID Prefix F0247	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.15(e)(2)	Completed
LSC	11/15/2016	LSC	11/15/2016	LSC	11/15/2016
ID Prefix F0278	Correction	ID Prefix F0279	Correction	ID Prefix F0323	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25(h)	Completed
LSC	11/15/2016	LSC	11/15/2016	LSC	11/15/2016
ID Prefix F0356	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.30(e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/15/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KL/KJ	DATE 12/13/2016	SIGNATURE OF SURVEYOR 28034	DATE 11/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/6/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1YC7

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(L1) **245519**
2.STATE VENDOR OR MEDICAID NO.
(L2) **883417100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COURAGE KENNY REHABILITATION INSTITUTE'S TRP**
(L4) **3915 GOLDEN VALLEY ROAD**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/01/2013**

6. DATE OF SURVEY **10/06/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Andrea Schmitz, HFE NE II — 10/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/22/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/23/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 24, 2016

Ms. Marcia Lindig, Administrator
Courage Kenny Rehabilitation Institute's Transitional Rehabilitation Program
3915 Golden Valley Road
Golden Valley, MN 55422

RE: Project Number S5519027

Dear Ms. Lindig:

On October 6, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at

the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathy Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: 320-223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 6, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE KENNY REHABILITATION INSTITUTE'S TRP	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 1 residents (R100) observed to be assisted with eating while staff stood next to him. Findings include: R100's admission Minimum Data Set (MDS) dated 9/7/16, identified R100 had severe cognitive impairment and required supervision with set-up assistance for eating.	F 241	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. F241-483.15(a) Courage Kenny Rehabilitation Institute□s TRP promotes care for residents in a manner and in an environment that	11/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE KENNY REHABILITATION INSTITUTE'S TRP	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 During observation of the evening meal service on 10/3/16, at 4:59 p.m. R100 was seated at a table in the main dining room in a standard non-electric wheelchair. Nursing assistant (NA)-A stood on the right side of R100 at the table and started to assist him with eating. At 5:27 p.m. food service supervisor (FSS)-A walked by the table as she cleared plates from other tables and provided no instruction to NA-A to be seated as she continued to assist R100 with eating while standing. At 5:34 p.m. NA-A removed the lid from a disposable ice cream dish and held it in her hand off the table while continuing to stand as R100 used a spoon to eat it. R100 and NA-A conversed throughout the meal about various topics, however, at each interaction R100 had to turn his head up at NA-A who continued to stand up as she assisted him with eating. R100 was assisted out of the dining room by NA-A at 5:36 p.m. having been assisted to eat 100% of the provided meal. When interviewed on 10/3/16, at 5:40 p.m. NA-A stated she stood while assisting R100 to eat because she felt, "More comfortable standing," and it was, "Easier for me to stand I guess." Further, NA-A stated she had observed other staff to stand while assisting residents to eat, but had no concerns with doing so, "I don't see a problem with it." During interview on 10/5/16, at 10:48 a.m., registered nurse (RN)-A stated staff should be at a height to have eye contact while assisting residents with eating. RN-A stated, "You don't want to be looking down on somebody," while assisting them to eat because, "I don't feel like its respectful."	F 241	maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality. Staff will be re-educated regarding maintaining dignity when assisting residents to eat, including R100. Client has been interviewed, and states that he feels staff treat him with dignity and respect. All staff will be inserviced regarding protecting and promoting resident dignity, including those who assist R100 to eat. A list of residents requiring assistance to eat has been compiled and will be updated weekly. The routine education provided to staff regarding resident rights, including dignity, has been reviewed and revised. This education will continue to be provided at the time of hire and annually. The Administrator or designee will complete weekly audits to ensure that resident dignity is maintained when they receive assistance to eat until the next QAPI meeting, 11/17/16. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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F 241	Continued From page 2 When interviewed on 10/5/16, at 11:03 a.m. RN-B stated R100 used a manual wheelchair for mobility and could not be left alone with food. RN-B stated meal times should be a pleasant time and not an assembly line. Further, RN-B stated it was not right for staff to stand while assisting residents with eating because it may affect their self esteem. An undated facility Straight Talk About Disability - A Guide to Basic Understanding and Common Courtesy policy identified, "When conversing at length with a person in a wheelchair, sit or place yourself at that person's eye level."	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate an identified bathing preference for 1 of 3 residents (R95) reviewed for choices. Findings include: R95's admission Minimum Data Set (MDS) dated 8/26/16 indicated the resident was cognitively intact and needed physical assistance with	F 242	F242 - 483.15(b) Courage Kenny Rehabilitation Institute□s TRP protects and promotes residents□ rights to choose activities, schedules, and health care consistent with their interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of their lives in the facility that are significant to them.	11/15/16

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F 242	Continued From page 3 bathing. During initial interview on 10/3/16, at 6:17 p.m. R95 stated he received showers, which he would prefer to have in the evening. R95 further stated he received showers in the morning after completing a daily bowel program. On 10/5/16, at 2:08 p.m. nursing assistant (NA)-D stated the admissions nurse and herself were in charge of asking residents upon admission about bathing preferences. She further stated residents received showers every other day, and staff could accommodate evening showers if requested. However, due to therapy schedules, it was easier to do showers in the morning so occupational therapy could assist. NA-D reported R95 received showers in the morning right after his bowel program. A facility document entitled: Client Care Sheet (used by the nursing assistants to care for residents) dated 10/5/16, directed R95 "requests shower in evening" under the comments section. When re-interviewed on 10/5/16, at 2:37 p.m. NA-D stated R95 had been scheduled for morning showers when he had been admitted, however, the showers were switched to the evenings due to pain control issues with his morning bowel program and therapy session. NA-D reported she thought the showers were re-scheduled for the morning when R95's pain was better controlled. She was not aware of when the shower times were switched, nor was she aware that R95 preferred evening showers stating R95 had never requested evening showers.	F 242	R95 has been interviewed regarding his bathing preferences, and his plan of care and nursing assistant assignment sheets have been revised as appropriate. All residents will be interviewed regarding their preferences for bathing times, and their plans of care and nursing assistant assignment sheets will be revised as appropriate. The admission nursing assessment will be reviewed and revised to ensure collection of bathing preferences. Staff will be inserviced regarding honoring resident preferences and on the use of the revised admission nursing assessment. The Administrator or designee will complete weekly audits of new admissions to ensure that resident preferences are honored related to bathing times until the next QAPI meeting, 11/17/16. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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F 242	Continued From page 4	F 242		

During an interview on 10/6/16, at 8:21 a.m. occupation therapist (OT)-C stated occupational therapy's goal when assisting residents to shower, was increased independence so showers could be safely performed with the nursing assistants. OT-C stated therapy had no impact on the showering schedule. In addition, OT-C stated her understanding was the number and timing of showers were given based on the amount of staff available, adding that scheduling showers was nursing's responsibility.

On 10/6/16, at 8:54 a.m. registered nurse (RN)-A stated scheduling of showers was on "a case by case basis." In addition, RN-A reported the admission nurse and/or lead nursing assistant interviewed new admissions regarding bathing preferences and thought the nursing admission assessment addressed bathing preferences. However, she further stated showers were dependent on the bowel program reporting that certain bowel medications needed to be given at certain times. RN-A stated R95 would have been placed on morning baths initially due to his morning bowel program, however, she acknowledged he must have requested evening showers per the Client Care Sheet. She stated R95 had never mentioned anything to her about wanting evening baths and would need to communicate that to staff, additionally stating "I don't see why not" when asking if evening showers could be accommodated.

When re-interviewed on 10/6/16, at 10:42 a.m. R95 stated he had never been asked about his shower preference on admission and disliked his morning showers because the mornings were already very rushed. R95 further stated he had received evening showers a couple of time, but

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F 242	Continued From page 5 not consistently, and reported asking "some staff" about getting evening showers; however, it was usually at shift change and would "usually have to ask twice in order for it to happen." A facility document entitled: Admission Nursing Assessment, dated 8/17/16, did not contain any questions regarding bathing preferences. A facility policy entitled Rights to Freedom of Choice, revised 8/20/01, identified resident rights including the right to choose schedules and the right to receive services with reasonable accommodation of needs and preferences. In addition, the policy directed "participants (residents) will meet with the Nurse Liaison and Program Liaison to identify their needs and preferences." A copy of R95's current care plan was requested but not provided.	F 242		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure notice of a new roommate was provided to 3 of 3 residents (R34, R93, R81) reviewed for facility admission, transfer and discharge practices. Findings include:	F 247	F247 - 483.15(e)(2) Courage Kenny Rehabilitation Institute's TRP protects and promotes the resident's right to receive notice before a room or roommate in the facility is changed. R81, R93, and R34 have been	11/15/16

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F 247	Continued From page 6 R34's quarterly Minimum Data Set (MDS) dated 8/16/16, identified R34 had intact cognition and demonstrated no behaviors. During interview on 10/3/16, at 7:05 p.m. R34 stated he had a roommate change, "About a month ago," and was not given any notice by the facility before the new roommate moved in. R34 added, "All of the sudden [he] just showed up." Further, R34 stated he would have liked notice before the new roommate moved in. R34's medical record was reviewed and lacked any evidence R34 had been notified of the new roommate prior to their arrival at the facility. R93's 14-day MDS dated 8/27/16, identified R93 had intact cognition and demonstrated no behaviors. During interview on 10/3/16, at 6:11 p.m. R93 stated he had not been provided any notice of his current roommate coming prior to his arrival. R93 stated he had been watching television in his room when the door opened and the roommate's family started bringing in personal belongings. Further, R93 stated he would have liked notice prior to the roommate coming, "So I could of been ready." R93's medical record was reviewed and lacked any evidence R93 had been notified of the new roommate prior to their arrival at the facility. R81's admission MDS dated 7/13/16, identified R81 had intact cognition and demonstrated no behaviors.	F 247	interviewed regarding any roommate concerns and were offered room changes, but they all declined that offer. All clients who currently have roommates, but for whom there is no documented notification, will be interviewed regarding any roommate concerns and will be offered a room change. Notification of all room and roommate changes will be documented in the medical record. The Roommate Notification policy and procedure has been reviewed and revised. Progress notes specifically for roommate notifications have been created in the electronic health record. Staff will be inserviced on the revised policy and procedure. The Administrator or designee will complete weekly audits to ensure that roommate change notifications are documented in accordance with the policy until the next QAPI meeting, 11/17/16. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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F 247	Continued From page 7 During interview on 10/4/16, at 11:23 a.m. R81 stated he had two roommate changes since coming to the facility, and he did not receive any notification of them coming prior adding the new roommates, "Just showed up." R81's medical record was reviewed and lacked any evidence R81 had been notified of the new roommate prior to their arrival at the facility. When interviewed on 10/5/16, at 3:19 p.m. admission liaison (AL)-A stated residents were provided verbal notice for new roommates adding the amount of notice varied, "It is sometimes twelve hours, and sometimes two days." AL-A stated she used a checklist system to ensure residents were notified, however, the documented checklists were destroyed and not saved as part of the medical record. A facility Roommate Notification policy dated 2/15, identified only a single sentence of direction, "Staff will notify clients of new roommates as soon as practicable." The policy lacked any direction or guidelines regarding documentation of this notification. No further information was provided.	F 247		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		11/15/16

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F 278	Continued From page 8 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was coded to reflect resident's current abilities for 2 of 3 residents (R97, R98) reviewed for activities of daily living. Findings include: R97's admission MDS dated 8/29/16, indicated R97 was cognitively intact and was independent with eating with set up help only. R97's 14 day MDS dated 9/3/16, indicated R97 needed supervision with eating with set up help only.	F 278	F278 - 483.20(g) - (j) Courage Kenny Rehabilitation Institute□s TRP ensures that assessments accurately reflect the resident□s status. The 14-day MDSs for R97 and R98 have been revised and resubmitted to CMS. The section of the MDS on activities of daily living (ADLs) such as eating and locomotion has been reviewed for accuracy for each current resident. The MDS Coordinator has developed a worksheet to be used when assessing residents□ level of assistance with ADLs. The MDS Coordinator will compare ADL coding to that on the prior assessment	

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F 278	Continued From page 9 During interview on 10/5/16, at 9:22 a.m. R97 stated that she ate independently after staff set up her tray. R97 stated that at no time had she needed any assistance with eating, since being in the facility. On 10/6/16, at 3:41 p.m., registered nurse (RN)-C stated after review of the documentation for R97 collected during the assessment window, she noted the documentation was in error and indicated R97 did not have a decline in her eating ability. RN-C stated she coded the MDS dated 9/3/16, in error and it would be resubmitted. Further, RN-C stated she was not aware of the error until today. R98's admission MDS dated 5/5/16, indicated R98 was independent with locomotion on and off the unit. R98's 14 day MDS dated 5/12/15, indicated R98 needed supervision with locomotion on and off the unit. During interview on 10/5/16, at 9:25 a.m. nursing assistant (NA)-A stated that R98 was always independent with mobility in the wheelchair. On 10/5/16, at 3:43 p.m. RN-C stated after review of the documentation for R98 collected during the assessment window she noted the documentation was in error and R98 did not have a decline in her locomotion abilities. RN-C stated she coded the MDS dated 5/12/16, in error and would be resubmitted. Further, RN-C stated she was not aware of the error until today. The facility policy MDS and Comprehensive	F 278	when applicable. The MDS Coordinator will review validation warnings before locking MDSs. Staff will be inserviced regarding the regulation. The Administrator or designee will complete weekly audits to ensure accurate coding of ADLs on new MDSs until the next QAPI meeting, 11/17/16. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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F 278	Continued From page 10 Assessment Process dated 1/1/96, indicated monthly triple audits are completed by the MDS coordinator, therapy and business office. The policy did not address coding errors.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop care plan interventions for safe smoking for 1 of 3 residents (R48) who smoked in the facility. Findings include:	F 279	F279 - 483.20(d), 483.20(k)(1) Courage Kenny Rehabilitation Institute□s TRP uses the results of the assessment to develop, review and revise the resident□s comprehensive plan of care. R84□s smoking safety was reassessed on 10/5/16, and it was found that he is	11/15/16

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F 279	Continued From page 11 R48's admission Minimum Data Set dated 6/8/16, indicated R48 had diagnoses which included quadriplegia, and chronic obstructive pulmonary disease (COPD). The MDS identified R48 was cognitively intact and required total assistance for all activities of daily living. R48's Smoking Safety Evaluation dated 7/18/16, indicated R48 needed extensive assistance with set up and lighting the cigarette. The smoking evaluation identified R48 was unable to ash properly, and recommended an occupational evaluation to be done due to R48 being very close to having the cigarette land on himself while smoking. R48's smoking assessment completed by an occupational therapist (OT) dated 7/19/16, identifed R48 was unable to light a cigarette, was inconsistent with disposing of ashes, but able to dispose of smoking materials. The OT recommended supervision with smoking, to wear an apron and utilize a smoking wand (a device to assist with smoking). R48's care plan dated 7/20/16,identified R48 had a problem with smoking related to physical limitations. The care plan indicated OT recommended a smoking wand to be used along with use of a smoking apron. R48's care plan did not address the supervision recommended by OT nor did R48's care plan address R48 needed assistance placing his cigarette in the smoking wand and lighting it. R48's Client Care Sheet dated 10/5/16, directed the nursing assistants to check for burn holes in clothing. The Client Care Sheet did not address supervision, smoking apron use or assistance	F 279	able to smoke safely independently with minimal setup, which he can direct and obtain from staff or peers. His plan of care and nursing assistant assignment sheet have been reviewed and revised. Residents are asked about smoking during the admission nursing assessment. Residents who smoke are further assessed for safety through observation and assessment. A list of residents who smoke has been compiled and will be updated weekly. Smoking Safety Evaluations, care plans, and nursing assistant assignment sheets of current residents who smoke have been reviewed and revised as needed. The smoking assessment policy/procedure has been reviewed and revised as appropriate. Staff will be inserviced regarding the regulation, using the specific example cited in the 2567. The Administrator or designee will complete weekly audits to ensure that assessment results are used to develop the care plans for residents who smoke. These audits will continue until the next QAPI meeting, 11/17/16. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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F 279	Continued From page 12	F 279		

with placing the cigarette in the smoking wand or the need for assistance with lighting the cigarette.

During observation on 10/3/16, at 4:38 p.m. R48 was seated in a wheelchair directly outside the front doors of the facility holding a smoking wand, smoking a cigarette in his right hand. There were no staff members present and R48 did not have on a smoking apron. When R48 was finished smoking, he moved his wheelchair closer to another resident (R86) who removed the cigarette from the cigarette wand and disposed of it in the ashtray for R48.

On 10/3/16, at 5:31 p.m. R48 was observed seated in a wheelchair in his room. R48 tried to pick up a pack of cigarettes, wand and lighter off his bed but could not grasp the items to put them on his lap. R48 put his call light and requested assistance to obtain his cigarettes, smoking wand and lighter. R48 stated he had used a smoking apron in the past, and stated he did not like the smoking apron and no longer used it. At that time, nursing assistant (NA)-B entered his room and R48 requested assistance to put his cigarettes, lighter and smoking wand on his lap. NA-B put the smoking materials on R48's lap. NA-B exited R48's room, and did not offer a smoking apron and did not accompany R48 outside to smoke.

On 10/3/16, at 5:44 p.m. R48 was seated outside the front door of the facility. R48 maneuvered his wheelchair next to R86, who was seated in the smoking area. R86 placed R48's cigarette into the wand, lit the cigarette for R48 and handed it to R48. R48 smoked the cigarette seated in the wheelchair, outside of the facility. R48 was not observed to attempt to remove the ashes, instead

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	245519	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE KENNY REHABILITATION INSTITUTE'S TRP	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 13	F 279		

let the wind blow the ashes off the tip of the cigarette. When R48 was done smoking he asked R86 for assistance in removing the cigarette from the smoking wand and extinguishing the cigarette. R48 stated if another resident was not available in the smoking area, nursing assistant would help him light his cigarette, but did not stay outside with him while he smoked. R48 stated he was "pretty sure" he could remove the ashes or cigarette if he dropped the cigarette on his body or clothing.

During interview on 10/5/16, at 9:09 a.m. NA-C stated sometimes R48 would call for help to set up his cigarette in the wand and light it for him outside. NA-C stated staff were to be outside with him but R48 does what he wanted to do. NA-C stated that she had not seen him wearing a smoking apron, and the smoking apron is stored in the downstairs nursing station. She indicated R48 stored his cigarettes and supplies in his backpack or his room.

On 10/5/16, at 9:14 a.m. NA-E stated R48 was independent with smoking and did not require supervision. NA-A stated at times R48 would ask for help to put the cigarette in the the smoking wand to go out and smoke with his buddies. NA-E stated she was not aware R48 needed a smoking apron.

On 10/5/16, at 9:18 a.m. NA-D stated the only thing R48 needed assistance with was putting the cigarette into the smoking wand and light it for him. NA-D stated she understood R48 had been "cleared" to not use a smoking apron. NA-D also stated the nursing assistants were to check his clothing for burn holes. NA-D confirmed R48's current client care sheet and confirmed the care

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F 279	Continued From page 14	F 279		

sheet directed to check for burn holes on R48's clothing and did not identify any other interventions related to smoking safety.

During interview on 10/5/16, at 10:29 a.m. RN-A stated the usual facility practice included a referral to occupational therapy for a smoking assessment to ensure the safety of smoking residents. RN-A stated if a residents functional ability changed, occupational therapy should reassess the resident for safety. RN-A stated R48 was issued a smoking apron, but she aware he did not wear it, and stated she was unsure when R48 started not using the smoking apron. RN-A stated a staff member should be outside observing him while he smoked according to his assessment and to her knowledge the staff were supervising him. RN-A stated nursing staff were responsible to apply and remove R48's smoking apron. RN-A stated occupational therapy was responsible for educating the resident on risk versus benefits of not using the smoking apron and stated she was not sure if OT was aware he was not wearing it. RN-A stated she would expect all smoking assessment recommendations to be included on the care plan and care sheet for staff to implement.

On 10/5/16, at 10:55 a.m. OT-A stated if there is a change in smoking function then that should be communicated to the therapy department so that a new assessment could be completed. OT-A stated when OT recommended supervision during smoking activity, she felt staff or family member needed to be by the resident's side, and not a another resident performing supervision.

On 10/5/16, at 11:17 a.m. OT-B confirmed R48's OT smoking assessment and confirmed she had

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F 279	Continued From page 15 recommended supervision in smoking, assistance with putting the cigarette in the wand and assistance with lighting as well as extinguishing the cigarette at times. OT-B stated it was common for residents abilities to change and indicated she would expect to be notified when residents health condition changed. Further, OT-B stated she had not re-assessed R48's smoking ability since in the initial assessment, and indicated she was not aware OT recommendations were not being followed for R48. During interview on 10/6/16, at 11:49 p.m. the director of nursing (DON) confirmed R48's smoking assessment interventions which included use of a smoking apron, smoking wand and supervision. R48 stated she would expect all recommendations should be on R48's care plan and care sheet for all staff to implement the interventions. Further, The DON stated that smoking assessments should be completed quarterly or when a residents condition changed. The facility policy Smoking Assessment dated 11/3/15, directed if a client was not able to smoke independently, personalized interventions must be put in place immediately to ensure the safety of the client. The policy indicated supervision while smoking would be provided by staff, family or friend that was not another client.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		11/15/16

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 323	Continued From page 16 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement individualized interventions to prevent smoking hazards for 1 of 3 residents (R48) observed to be smoking. Findings include: R48's admission Minimum Data Set dated 6/8/16, indicated R48 had diagnoses which included quadriplegia, and chronic obstructive pulmonary disease (COPD). The MDS identified R48 was cognitively intact and required total assistance for all activities of daily living. R48's Smoking Safety Evaluation dated 7/18/16, indicated R48 needed extensive assistance with set up and lighting the cigarette. The smoking evaluation identified R48 was unable to ash properly, and recommended an occupational evaluation to be done due to R48 being very close to having the cigarette land on himself while smoking. R48's smoking assessment completed by an occupational therapist (OT) dated 7/19/16, identified R48 was unable to light a cigarette, was inconsistent with disposing of ashes, but able to dispose of smoking materials. The OT recommended supervision with smoking, to wear an apron and utilize a smoking wand (a device to assist with smoking).	F 323	F323 - 483.25(h) Courage Kenny Rehabilitation Institute□s TRP ensures that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. R84□s smoking safety was reassessed on 10/5/16, and it was found that he is able to smoke safely independently with minimal setup, which he can direct and obtain from staff or peers. His plan of care and nursing assistant assignment sheet have been reviewed and revised. Residents are asked about smoking during the admission nursing assessment. Residents who smoke are further assessed for safety through observation and assessment. A list of residents who smoke has been compiled and will be updated weekly. Smoking Safety Evaluations, care plans, and nursing assistant assignment sheets of current residents who smoke have been reviewed and revised as needed. The smoking assessment policy/procedure has been reviewed and revised as appropriate. Staff will be inserviced regarding the regulation, using the specific example cited in the 2567. The Administrator or designee will complete weekly audits to ensure that	

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F 323	Continued From page 17 R48's medical record did not include any further assessments for safe smoking for R48. R48's care plan dated 7/20/16,identified R48 had a problem with smoking related to physical limitations. The care plan indicated OT recommended a smoking wand to be used along with use of a smoking apron. R48's care plan did not address the supervision recommended by OT nor did R48's care plan address R48 needed assistance placing his cigarette in the smoking wand and lighting it. R48's Client Care Sheet dated 10/5/16, directed the nursing assistants to check for burn holes in clothing. The Client Care Sheet did not address supervision, smoking apron use or assistance with placing the cigarette in the smoking wand or the need for assistance with lighting the cigarette. During observation on 10/3/16, at 4:38 p.m. R48 was seated in a wheelchair directly outside the front doors of the facility holding a smoking wand, smoking a cigarette in his right hand. There were no staff members present and R48 did not have on a smoking apron. When R48 was finished smoking, he moved his wheelchair closer to another resident (R86) who removed the cigarette from the cigarette wand and disposed of it in the ashtray for R48. On 10/3/16, at 5:31 p.m. R48 was observed seated in a wheelchair in his room. R48 tried to pick up a pack of cigarettes, wand and lighter off his bed but could not grasp the items to put them on his lap. R48 put his call light and requested assistance to obtain his cigarettes, smoking wand and lighter. R48 stated he had used a smoking	F 323	assessment results are used to develop the care plans for residents who smoke. These audits will continue until the next QAPI meeting, 11/17/16. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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F 323	Continued From page 18	F 323		

apron in the past, and stated he did not like the smoking apron and no longer used it. At that time, nursing assistant (NA)-B entered his room and R48 requested assistance to put his cigarettes, lighter and smoking wand on his lap. NA-B put the smoking materials on R48's lap. NA-B exited R48's room, and did not offer a smoking apron and did not accompany R48 outside to smoke.

On 10/3/16, at 5:44 p.m. R48 was seated outside the front door of the facility. R48 maneuvered his wheelchair next to R86, who was seated in the smoking area. R86 placed R48's cigarette into the wand, lit the cigarette for R48 and handed it to R48. R48 smoked the cigarette seated in the wheelchair, outside of the facility. R48 was not observed to attempt to remove the ashes, instead let the wind blow the ashes off the tip of the cigarette. When R48 was done smoking he asked R86 for assistance in removing the cigarette from the smoking wand and extinguishing the cigarette. R48 stated if another resident was not available in the smoking area, nursing assistant would help him light his cigarette, but did not stay outside with him while he smoked. R48 stated he was "pretty sure" he could remove the ashes or cigarette if he dropped the cigarette on his body or clothing.

During interview on 10/5/16, at 9:09 a.m. NA-C stated sometimes R48 would call for help to set up his cigarette in the wand and light it for him outside. NA-C stated staff were to be outside with him but R48 does what he wanted to do. NA-C stated that she had not seen him wearing a smoking apron, and the smoking apron is stored in the downstairs nursing station. She indicated R48 stored his cigarettes and supplies in his

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F 323	Continued From page 19	F 323		

backpack or his room.

On 10/5/16, at 9:14 a.m. NA-E stated R48 was independent with smoking and did not require supervision. NA-A stated at times R48 would ask for help to put the cigarette in the the smoking wand to go out and smoke with his buddies. NA-E stated she was not aware R48 needed a smoking apron.

On 10/5/16, at 9:18 a.m. NA-D stated the only thing R48 needed assistance with was putting the cigarette into the smoking wand and light it for him. NA-D stated she understood R48 had been "cleared" to not use a smoking apron. NA-D also stated the nursing assistants were to check his clothing for burn holes. NA-D confirmed R48's current client care sheet and confirmed the care sheet directed to check for burn holes on R48's clothing and did not identify any other interventions related to smoking safety.

During interview on 10/5/16, at 10:15 a.m. registered nurse (RN)-D stated the nursing staff would try to supervise him outside but he did not always let staff know he was going outside to smoke. RN-D stated she was aware R48 had not used the smoking apron, but stated she felt it was his right to refuse the apron. RN-D stated R48 should have been re-educated on smoking safety, when he refused the smoking apron. RN-D stated she was not sure if OT was aware R48 did not use the smoking apron.

R48's medical record lacked documentation R48 refused the use of the smoking apron.

During interview on 10/5/16, at 10:29 a.m. RN-A

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F 323	Continued From page 20	F 323		

stated the usual facility practice included a referral to occupational therapy for a smoking assessment to ensure the safety of smoking residents. RN-A stated if a residents functional ability changes, occupational therapy should reassess the resident for safety. RN-A stated R48 was issued a smoking apron, but she aware he did not wear it, and stated she was unsure when R48 started not using the smoking apron. RN-A stated a staff member should be outside observing him while he smoked according to his assessment and to her knowledge the staff were supervising him. RN-A stated nursing staff were responsible to apply and remove R48's smoking apron. RN-A stated occupational therapy was responsible for educating the resident on risk versus benefits of not using the smoking apron and stated she was not sure if OT was aware he was not wearing it. RN-A stated she would expect all smoking assessment recommendations to be included on the care plan and care sheet for staff to implement.

On 10/5/16, at 10:55 a.m. OT-A stated if there is a change in smoking function then that should be communicated to the therapy department so that a new assessment could be completed. OT-A stated when OT recommended supervision during smoking activity, she felt staff or family member needed to be by the resident's side, and not a another resident performing supervision.

On 10/5/16, at 11:17 a.m. OT-B confirmed R48's OT smoking assessment and confirmed she had recommended supervision in smoking, assistance with putting the cigarette in the wand and assistance with lighting as well as extinguishing the cigarette at times. OT-B stated it was common for residents abilities to change

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F 323	Continued From page 21 and indicated she would expect to be notified when residents health condition changed. Further, OT-B stated she had not re-assessed R48's smoking ability since in the initial assessment, and indicated she was not aware OT recommendations were not being followed for R48. During interview on 10/6/16, at 11:49 p.m. the director of nursing (DON) confirmed R48's smoking assessment interventions which included use of a smoking apron, smoking wand and supervision. R48 stated she would expect all recommendations should be on R48's care plan and care sheet for all staff to implement the interventions. Further, The DON stated that smoking assessments should be completed quarterly or when a residents condition changed. The facility policy Smoking Assessment dated 11/3/15, directed if a client was not able to smoke independently, personalized interventions must be put in place immediately to ensure the safety of the client. The policy indicated supervision while smoking would be provided by staff, family or friend that was not another client.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.	F 356		11/15/16

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F 356	Continued From page 22 - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the nurse staff posting was posted in a place readily accessible to residents and visitors. This had the potential to affect all 41 residents residing in the facility. Findings include: On 10/3/16, at 1:19 p.m. an initial tour of the facility began and the nurse staff posting was located at 10/3/16, at 1:35 p.m. The nurse staff posting was observed on the ground level behind the nursing station, accessible only to staff, on a bulletin board behind the nursing station desk. The posting had another document covering half	F 356	F356 - 483.30(e) Courage Kenny Rehabilitation Institute□s TRP posts nurse staffing data in a clear and readable format and in a prominent place readily accessible to residents and visitors. The designated location for the staffing data was moved to a lucite stand on the nursing station countertop at the time of the survey. The Nursing Staffing Posting policy and procedure will be reviewed and revised. Staff will be inserviced on the new policy and procedure. The Administrator or designee will	

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F 356	Continued From page 23 of the page and required information was not able to be observed by a resident or visitor standing at the desk. On 10/4/16, at 1:41 p.m. the nurse staff posting was again observed to be located in the same place with a document again covering half the page. During interview on 10/4/16, at 1:48 p.m. the staffing coordinator (SC)-A stated that the nurse staff posting was part of regulation and that she was responsible for filling out, and posting the nurse staff posting. The SC-A further stated that she had been told to post the nurse staff posting on the bulletin boards inside the ground and first floor nursing stations. The SC-A observed the posting at the ground floor nursing station and stated that although the nurse posting could be viewed the information could not be read from its current location. During interview on 10/6/16, at 11:43 p.m. the administrator stated that the nurse staff posting's purpose was for resident and families to know what the staffing was like in the facility. The administrator further stated that where the staff posting was hung, she thought, was viewable to residents and families. The facility's untitled policy dated 12/7/05, directed staff to post the nurse staffing information in a "prominent place readily accessible to residents and visitors."	F 356	complete weekly audits to ensure that the nurse staffing data is posted correctly until the next QAPI meeting, 11/17/16. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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	245519	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/06/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 06, 2016. At the time of this survey, Courage Kenny Rehabilitation Institute was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was determined to be of Type II(111) construction. It has no basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 41 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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	245519	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE KENNY REHABILITATION INSTITU	**3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 06, 2016. At the time of this survey, Courage Kenny Rehabilitation Institute was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was determined to be of Type II(111) construction. It has no basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 41 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.