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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DIJI

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: **7** (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 **12/21/2015** (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:

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
	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 :
Christine Bodick-Nord, HFE NE II — 12/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/04/2015 (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 01/04/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/08/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245519
January 4, 2016

Mr. Matthew Kinne, Administrator
Courage Kenny Rehabilitation Institute's Transitional Rehabilitation Program
3915 Golden Valley Road
Golden Valley, Minnesota 55422

Dear Mr. Kinne:

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 December 14, 2015 the above facility is certified for or recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 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

MDH
Minnesota
Department
of Health

Electronically delivered
November 20, 2015

Mr. Matthew Kinne, Administrator
Courage Kenny Rehabilitation Institute's Trp
3915 Golden Valley Road
Golden Valley, Minnesota 55422

RE: Project Number S5519026

Dear Mr. Kinne:

On November 5, 2015, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on November 5, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Jessica Sellner, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Jessica.sellner@state.mn.us

Phone: (320) 223-7343
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 25, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323 (S/S=J), effective November 5, 2015. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Courage Kenny Rehabilitation Institute's Trp is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 5, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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.

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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 February 5, 2016 (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 May 5, 2016 (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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245519

December 30, 2015
By Certified Mail

Mr. Matthew Kinne, Administrator
Courage Kenny Rehabilitation Institute's
Transitional Rehabilitation Program
3915 Golden Valley Road
Golden Valley, MN 55422

Dear Mr. Kinne:

SUBJECT: SURVEY FINDINGS AND IMPOSITION OF REMEDY
Cycle Start Date: November 5, 2015

SURVEY RESULTS
On November 3, 2015, a Life Safety Code and on November 5, 2015, a health survey were completed at Courage Kenny Rehabilitation Institute's Transitional Rehabilitation Program (TRP) by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency to place the health and safety of your residents in immediate jeopardy. This deficiency was cited at scope and severity (S/S) level J, as follows:

- F323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices.

In addition, the above cited deficiency constitutes substandard quality of care (SQC) and an extended survey was performed.

Surveyors found a situation of immediate jeopardy to resident health and safety that was removed on November 5, 2015. However, they also found that your facility continued to not be in substantial compliance with Federal requirements with the most serious deficiency at a severity level 2.

The State agency advised you of the deficiency that led to this determination and provided you with a copy of the survey report (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
Based on the survey findings, the State survey agency notified you they were recommending that the CMS impose a remedy:

- Civil Money Penalty effective November 2, 2015

On December 21, 2015, the State survey agency conducted a revisit to your facility and found that your facility was in substantial compliance as of November 6, 2015. As a result, the following actions related to remedies are being taken:

- State Monitoring, which was to be effective November 25, 2015, is rescinded
- Mandatory Denial of Payment, which was to be effective February 5, 2016, will not be imposed
- Mandatory Termination, which was to be effective May 5, 2016, will not be imposed
- See Civil Money Penalty below

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488 Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

CIVIL MONEY PENALTY

In determining the amount of the Civil Money Penalty (CMP) that we are imposing for each day of noncompliance, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR §488.404. We are imposing the following CMP:

- Federal Civil Money Penalty of $3,900.00 per day for the three (3) days beginning November 2, 2015 and continuing through November 4, 2015 for a total of $11,700.00
- Federal Civil Money Penalty of $100.00 for the one day, November 5, 2015

The total amount of the CMP imposed is $11,800.00.

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted to this office within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes

Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

CMP CASE NUMBER
A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 245519.
- The start date for this cycle is November 5, 2015.

CMP PAYMENT
When due, the CMP is payable by check to CMS at the following address:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
Post Office Box 7520
Baltimore, MD 21207

If you use a delivery service, such as Federal Express, **use the following address only**:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
7500 Security Boulevard
Baltimore, MD 21244

Note that your check must be sent to one of the above addresses--not to the Chicago Regional Office. However, a **copy** of your check and, if applicable, **your waiver of your right to a hearing must be sent to the attention of Jan Suzuki at the Chicago Regional Office.** Failure to do so could result in our office proceeding with collection of the full amount of the CMP.

If the total amount of the CMP is not received by the due date, interest will be assessed in

accordance with the regulations at 42 CFR §488.442 on the unpaid balance of the penalty beginning on the due date. The Federal rate of interest is 10%. The CMP, and any interest accrued after the due date, will be deducted from sums owing to you **without any further notification from this office.**

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601-5519. **The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.**

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Because the facility was subject to an extended survey, this provision is applicable to your facility. Therefore, Courage Kenny Rehabilitation Institute's TRP is prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 5, 2015. You will receive further information regarding this from the State agency. This prohibition remains in effect for the specified period even though other actions relating to remedies are being taken, as indicated above. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met. This prohibition is not subject to appeal.

APPEAL RIGHTS

The State survey agency previously advised of your right to appeal the noncompliance that resulted in the finding of SQC which resulted in the loss of NATCEP approval. Please refer to that notice and note the deadline for that appeal.

This formal notice imposed:

- Civil Money Penalty effective November 2, 2015

If you disagree with the findings of noncompliance which resulted in this imposition, you or your

legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice. It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki. Failure to do so could result in our office proceeding with collection of the CMP.

INFORMAL DISPUTE RESOLUTION
The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visit. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR §488.431, when a civil money penalty subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, 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 (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to: www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

CONTACT INFORMATION
If you have any questions regarding this matter, please contact me at (312) 886-5209. Information may also be faxed to (443) 380-6602.

Sincerely,

Jan Suzuki
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245519

December 30, 2015

Andrew M. Luger, United States Attorney
District of Minnesota
600 U.S. Court House, 300 South 4th St.
Minneapolis, MN 55415

Attention: Chief, Civil Division

Dear Mr. Andrew M. Luger, United States Attorney:

This is to notify you of the imposition of a civil money penalty against Courage Kenny Rehabilitation Institute's Trp, 3915 Golden Valley Road, Golden Valley, MN 55422 pursuant to sections 1819(h) and 1919(h) of the Social Security Act ("Act"), codified at 42 U.S.C. section 1395i-3(h) and 1396r(h), and the enforcement regulations specified at 42 C.F.R. Part 488. 59 Reg. 56116 et. seq. To participate in the Medicare and Medicaid programs, long-term care facilities must meet Federal participation requirements, as specified in regulations at 42 C.F.R. Part 483, subparts A through C. The Act provides that the Secretary of the Department of Health and Human Services may impose civil money penalties against facilities for noncompliance with program participation requirements. That authority has been delegated to the Centers for Medicare & Medicaid Services (CMS).

Under the Act, CMS may impose a civil money penalty, but only pursuant to an agreement with the Attorney General. See 42 U.S.C. section 1320a-7(c), incorporated by reference in 42 U.S.C. section 1395i-3(h) and 1396r(h). Under the terms of the current agreement between CMS and the Department of Justice, your office has 14 days to review this matter. Therefore, pursuant to the agreement, this letter serves as notice of CMS' imposition of a civil money penalty against Courage Kenny Rehabilitation Institute's Trp, pursuant to 42 U.S.C. section 1395i-3(h)(2) and 1396r(h)(3). We are notifying you of our action in the event that such action might adversely affect any pending criminal action or other investigation of the facility, or raise "double jeopardy" issues. If you do not respond within 14 days of receipt of this notice, CMS will be free to collect, or accept payment of, the civil money penalty.

On November 5, 2015, a health survey was completed at Courage Kenny Rehabilitation Institute's Trp by the Minnesota Department of Health to determine whether the facility was in compliance with Federal requirements for nursing homes participating in the Medicare and Medicaid programs. Surveyors found evidence that the facility was not in substantial compliance with participation requirements. As a result of the survey findings, CMS is imposing, among

other remedies, a civil money penalty as follows:

- Federal Civil Money Penalty of $3,900.00 per day for the three (3) days beginning November 2, 2015 and continuing through November 4, 2015 for a total of $11,700.00
- Federal Civil Money Penalty of $100.00 for the one day, November 5, 2015

The facility will be advised of the impending remedies, including the imposition of a civil money penalty, in a letter from this office.

Thank you very much for your cooperation in this matter. If you have any questions regarding the issues presented in this notice, please contact me at (312) 886-5209. Should you have any legal questions, please contact Marion Wanless, of the Office of General Counsel, at (312) 886-2552.

Sincerely,

Jan Suzuki
Principal Program Representative
Long Term Care Certification
& Enforcement Branch

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 4, 2016

Mr. Matthew Kinne, Administrator
Courage Kenny Rehabilitation Institute's Transitional Rehabilitation Program
3915 Golden Valley Road
Golden Valley, Minnesota 55422

RE: Project Number S5519026

Dear Mr. Kinne:

On November 20, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 25, 2015. (42 CFR 488.422)

On December 30, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per day civil money penalty of 3,900, effective November 2, 2015. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of 100 for the deficiency cited at F323, effective November 5, 2015. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 5, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on November 5, 2015. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On December 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on November 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 14, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on November 5, 2015, as of December 14, 2015

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 14, 2015.

However, as we notified you in our letter of November 20, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 5, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 30, 2015:

- Per day civil money penalty of $3,900.00 for the three (3) days beginning November 2, 2015, be discontinued as of November 4, 2015 for a total of $11,700.00. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $100.00 for the deficiency cited at F323, effective November 5, 2015 for a total penalty of $100.00 will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 5, 2016 be rescinded as of December 14, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245519	A. Building B. Wing	12/21/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	11/06/2015	ID Prefix F0323 Reg. # 483.25(h) LSC	11/06/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 11/5/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 4, 2016

Mr. Matthew Kinne, Administrator
Courage Kenny Rehabilitation Institute's Transitional Rehabilitation Program
3915 Golden Valley Road
Golden Valley, Minnesota 55422

Re: Reinspection Results - Project Number S5519026

Dear Mr. Kinne:

On December 21, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 5, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with 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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DIJI

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 **11/05/2015** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Annette Truebenbach, HFE NE II 12/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/07/2015 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 12/08/2015 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Electronically delivered
November 20, 2015

Mr. Matthew Kinne, Administrator
Courage Kenny Rehabilitation Institute's Trp
3915 Golden Valley Road
Golden Valley, Minnesota 55422

RE: Project Number S5519026

Dear Mr. Kinne:

On November 5, 2015, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on November 5, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Jessica Sellner, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Jessica.sellner@state.mn.us

Phone: (320) 223-7343
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 25, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323 (S/S=J), effective November 5, 2015. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Courage Kenny Rehabilitation Institute's Trp is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 5, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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.

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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 February 5, 2016 (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 May 5, 2016 (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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	11/05/2015

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 A survey was conducted by the Minnesota Department of Health on 11/2/15, through 11/5/15. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's lack of implementing interventions as assessed to ensure resident safety when smoking, which resulted in the high potential for harm or death. The IJ began on 9/16/15, when the facility completed R53's Smoking Safety Evaluation which identified R53 was not able to safely utilize lighter/matches and was unable to handle lit smoking material. The facility was notified of the IJ on 11/2/15, at 5:50 p.m., and it was removed on 11/5/15, at 9:54 a.m. 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. An extended survey was conducted by the Minnesota Department of Health on 11/3/15, and 11/4/15.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		12/14/15

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

Electronically Signed | 11/30/2015

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 _____	11/05/2015

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F 282	Continued From page 1 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility to ensure the care plan was implemented for 1 of 7 residents (R53) reviewed for smoking. Findings include: R53's admission Minimum Data Set (MDS) dated 6/4/15, indicated R53 had no cognitive impairment and required extensive staff assistance with all ADLs (activities of daily's living). R53's care area assessment (CAA) dated 6/4/15, indicated the resident had physical limitations including weakness, limited range of motion, and poor coordination with all ADL's. R53's care plan dated 9/16/15, indicated the resident smoked tobacco and staff were directed R53 required staff supervision, or supervision from another person who could functionally safely assist R53 with smoking. The care plan also directed staff to monitor R53 for cigarette burns and ensure the resident was smoking safety. During interview on 11/2/15, at 3:00 p.m. R53 stated she was able to go outside in the facility smoking area to smoke independently, and did not need staff assistance or supervision while smoking. R53 stated she carried her cigarettes and lighter with her, and goes outside and	F 282	This Plan constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan is not an admission that a deficiency exists or that one was cited correctly. This is submitted to meet requirements established by state and federal law. F282 The services provided or arranged by Courage Kenny Rehabilitation Institute□s Transitional Rehab Program are provided by qualified persons in accordance with each client□s written plan of care. R53□s smoking safety was reassessed on 11/3/15. Her plan of care and nursing assistant assignment sheet were reviewed and revised with her input. Supervision of R53□s smoking will be provided by staff or specific members of her family (mother, husband, and sister) who have been educated about her needs. R53 was offered the opportunity to create a smoking schedule or for staff to offer to take her outside to smoke. Instead, she has chosen to request assistance when she wishes to smoke. R53 was asked whether she would be willing to surrender her smoking materials to staff, to ensure she would not smoke unsupervised. R53 refused to give up control of her smoking materials, but	

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F 282	Continued From page 2 another resident would light her cigarette for her. R53 stated she was not able to hold the cigarette with her hands, however she held the cigarette between her teeth and lips, and when she needed to "ash" her cigarette, she turned her head to the side and blows the ashes off. When R53 finished the cigarette, she blew, or spit, out the cigarette onto the ground. R53 stated she had recently dropped a cigarette onto the fleece lap blanket she draped across her lap, and the blanket got a burn hole in. R53 pointed to the lap blanket across her lap which was observed to have two burn holes that went all the way through the blanket; one was the approximate size of a penny, and the other was approximately the size of a number two pencil eraser. The blanket was also observed to have several singed marks on the blanket. During observation on 11/2/15, at 3:09 p.m. R53 was observed wheeling the electric wheelchair outside into the facility smoking area. R53 asked another resident who was in a motorized wheel chair to obtain her cigarettes out of her backpack. The other resident got a cigarette for R53, put the cigarette into his mouth, lit it, and then placed the lit cigarette into R53's mouth. R53 held the cigarette in between her teeth and lips while talking with other residents, and the cigarette was observed moving up and down as she talked. R53 was wearing a knit scarf which was looped around her neck, and had the fleece lap blanket draped across her lap. As R53 smoked, she would turn her head to the right and blew, making a whistling sound, while the ashes were blowing away from R53's end of the cigarette and some of the gray ashes were observed landing on her right arm. When R53 was finished smoking, she spit out the lit cigarette butt on to the ground to	F 282	agreed to wear a wanderguard bracelet to alert staff if she were to go outside unsupervised. R53 was also provided a smoking apron, but it is not a required element of her care plan, as supervision will be provided when she smokes. Staff were notified of the changes to R53□s care plan by an email, during shift-to-shift report for two days, and by a posting in the staff workrooms reminding them that changes are frequently made to care plans and assignment sheets, and to review them daily. Clients are asked about smoking during the admission nursing assessment. Clients who smoke are further assessed for safety through observation and assessment. Smoking Safety Evaluations and care plans of current clients who smoke have been reviewed and revised as needed. Nursing assistant assignment sheets direct staff to monitor the clothing/belongings of clients who smoke, and to report burns to the nurse so the client□s smoking safety can be re-evaluated. The smoking policy/procedure has been reviewed and revised. A smoking assessment policy/procedure has been developed. Staff will receive training on the new policies and procedures and the importance of following the care plan using the specific example cited in the 2567. The Director of Nursing or designee will complete daily audits to ensure R53 is receiving adequate supervision to smoke, until the next QAPI meeting, 12/17/15. In addition, until the 12/17/15 QAPI meeting,	

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F 282	Continued From page 3 the right of her, and another resident attempted to roll over the lit cigarette butt with his wheelchair, however, he missed running it over both times. During interview on 11/4/15, at 6:53 p.m. registered nurse (RN)- A stated according to R53's care plan, the resident should be monitored by staff while smoking for safety, however, staff were not following the care plan. Facility policy on following the plan of care was requested but not received from the facility.	F 282	facility leadership will conduct audits five times per week to identify newly admitted clients who smoke or clients with changes in smoking behavior or ability, and ensure that assessment and care-planning is completed appropriately for them. The Director of Nursing will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	
F 323 SS=J	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 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an individualized smoking assessment which included providing supervision and ensuring safety measures were put into place for 1 of 7 residents (R53) who currently smoked unsupervised at the facility. This resulted in immediate jeopardy (IJ) for R53 who was at risk of serious injury when the facility failed to ensure a comprehensive Smoking Safety Assessment was completed, and interventions were	F 323	This Plan constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan is not an admission that a deficiency exists or that one was cited correctly. This is submitted to meet requirements established by state and federal law. F323 Courage Kenny Rehabilitation Institute□s	12/14/15

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F 323	Continued From page 4 implemented to ensure the resident was safe to smoke unsupervised. The immediate jeopardy began on 9/16/15, when R53's Smoking Safety Evaluation identified R53 was not able to safely utilize lighter/matches, was unable to safely handle lit smoking material, and indicated, "Client is unable to smoke outside independently due to physical function." However, R53 was observed smoking independently and was receiving assistance from other residents with no staff present, and was also observed to have cigarette burn holes in the fleece blanket that covered her lap. On 11/2/15, at 5:50 p.m. the administrator and director of nursing (DON) were notified of the IJ for R53. The IJ was removed on 11/5/15, at 9:54 a.m. but noncompliance remained at an isolated scope and severity level, which indicated potential for actual harm that is not an immediate jeopardy (Level D). Findings include: R53's admission Minimum Data Set (MDS) dated 6/4/15, indicated R53 had no cognitive impairment, and required total staff assistance for bed mobility, transfers, dressing, personal hygiene, and toileting. The MDS indicated R53 had diagnoses including quadriplegia (paralysis resulting in partial or total loss of use of the limbs), anxiety, and muscle weakness. R53's Care Area Assessment (CAA) dated 6/4/15, indicated R53 had physical limitations including weakness, limited range of motion, and poor coordination with all activities of daily living (ADL's).	F 323	Transitional Rehab Program ensures that the client environment remains as free of accident hazards as is possible; and each client receives adequate supervision and assistance devices to prevent accidents. R53□s smoking safety was reassessed on 11/3/15. Her plan of care and nursing assistant assignment sheet were reviewed and revised with her input. Supervision of R53□s smoking will be provided by staff or specific members of her family (mother, husband, and sister) who have been educated about her needs. R53 was offered the opportunity to create a smoking schedule or for staff to offer to take her outside to smoke. Instead, she has chosen to request assistance when she wishes to smoke. R53 was asked whether she would be willing to surrender her smoking materials to staff, to ensure she would not smoke unsupervised. R53 refused to give up control of her smoking materials, but agreed to wear a wanderguard bracelet to alert staff if she were to go outside unsupervised. R53 was also provided a smoking apron, but it is not a required element of her care plan, as supervision will be provided when she smokes. Staff were notified of the changes to R53□s care plan by an email, during shift-to-shift report for two days, and by a posting in the staff workrooms reminding them that changes are frequently made to care plans and assignment sheets, and to review them daily. Clients are asked about smoking during the admission nursing assessment. Clients who smoke are further assessed	

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F 323	Continued From page 5 R53's care plan dated 9/16/15, indicated R53 smoked tobacco, and instructed staff the resident required staff supervision, or supervision from another person who could functional safely to assist R53 with smoking, however, the care plan did not identify if this was family, friends, and/or other residents in the facility. The care plan also directed staff to monitor R53 for cigarette burns and ensure the resident was smoking safely. R53's Smoking Safety Evaluation dated 9/16/15, indicated R53 smoked 3-4 times a day, had been observed during smoking, and the resident did not always smoke in the designated smoking area indicating, "There are times when client is seen smoking outside of building close to trees outside of facility, which is not near the designated smoking area." The Smoking Safety Evaluation also identified the resident was not able to safely utilize lighter/ matches, could not safely handle lit smoking material, did not use/wear appropriate safety devices, had no holes in clothing or belongings, and therapy had reviewed resident's physical function related to smoking. The evaluation summary of the data collection indicated, "Client was not smoking upon admission to the facility, but did start smoking again with other clients. One client noted to be assisting her with smoking and other friends of client have been assisting her with this. Client is unable to smoke outside independently due to physical function. Client does not sit with cigarette in her mouth or hold cigarette in her hand independently. Client has had assistance with this. Client has been safe with smoking thus far. Smoking apron has been ordered by administrator for safety." Although the Smoking Safety Evaluation indicated the resident was not able to safely utilize lighter/ matches, and could	F 323	for safety through observation and assessment. Smoking Safety Evaluations and care plans of current clients who smoke have been reviewed and revised as needed. Nursing assistant assignment sheets direct staff to monitor the clothing/belongings of clients who smoke, and to report burns to the nurse so the client□s smoking safety can be re-evaluated. The smoking policy/procedure has been reviewed and revised. A smoking assessment policy/procedure has been developed. Staff will receive training on the new policies and procedures as well as the importance of providing adequate supervision and maintaining a client environment that is as free of accident hazards as possible, using the specific example cited in the 2567. The Director of Nursing or designee will complete daily audits to ensure R53 is receiving adequate supervision to smoke, until the next QAPI meeting, 12/17/15. In addition, until the 12/17/15 QAPI meeting, facility leadership will conduct audits five times per week to identify newly admitted clients who smoke or clients with changes in smoking behavior or ability, and ensure that assessment and care-planning is completed appropriately for them. The Director of Nursing will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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not safely handle lit smoking material, there was no further assessment to determine how the facility would ensure R53 would be kept safe when smoking.

During interview on 11/2/15, at 1:59 p.m. R53 stated she was able to go outside independently and received assistance from other residents to smoke. R53 stated she required assistance to smoke and would have another resident place a cigarette in her mouth and light it for her, and that she would hold the cigarette between her teeth and lips, and would turn her head when she needed to ash the cigarette. R53 stated when she was done with the cigarette, she would turn her head to the side and "blow" the cigarette out of her mouth onto the ground, as she is not able to use her hands/arms to hold the cigarette. R53 stated she did not wear a smoking apron, nor was she instructed by the facility she was required to use or wear any specialized equipment when smoking.

During interview on 11/2/15, at 2:55 p.m. nursing assistant (NA)-D stated R53 kept her cigarettes and lighter with her in her backpack. NA-D stated she was not aware R53 had any safety concerns with smoking, and stated staff were not instructed the resident needed to be supervised when smoking.

During a follow up interview on 11/2/15, at 3:00 p.m. R53 stated she'd recently obtained a burn hole from a cigarette she had dropped on a fleece blanket she had laid across her lap. R53 stated she'd gotten the blanket when she was admitted to the facility, and verified she started to smoke shortly after her admission. R53 stated she was able to go outside and smoke without

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staff supervision, and received assistance from other residents or friends to obtain, and light her cigarettes. R53 stated her peers would assist her with lighting the cigarette, and at times they would go back into the facility because once the cigarette was lit, she was able to stay outside alone and finish her cigarette. R53 was observed with a fleece blanket laying across her lap which had two burn holes that went all the way through the blanket. One of the burn holes was approximately the size of a penny, and the other was approximately the size of a number two pencil eraser. The fleece blanket was also observed to have multiple singed marks.

During observation on 11/2/15, at 3:09 p.m. R53 was observed outside the facility in the designated smoking area smoking a cigarette. There were no staff present outside. R53 asked another resident in a motorized wheel chair to obtain a cigarette out of her backpack and light it for her. The other resident got a cigarette out of R53's backpack, placed it into his mouth and lit it, and then placed the lit cigarette into R53's mouth. R53 held the cigarette between her teeth and lips, and while she was talking with other residents the cigarette was moving up and down in her mouth. R53 was wearing a knit scarf which was looped around her neck, had the fleece blanket laying over her lap, and was not wearing a smoking apron nor did she have any other smoking safety device(s) in place. During observation of R53 smoking, she would turn her head to the right, and blow, making a whistling sound, to get the ashes off the end of the cigarette. Some of the gray ashes were observed landing on R53's right arm. When R53 finished the cigarette, she turned her head to the right, and spit/ blew the cigarette out of her mouth onto the ground.

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Another resident in a wheelchair attempted to roll over the lit cigarette to put it out however, the resident was unable to extinguish the cigarette after attempting to roll over it two times and missing the cigarette.

During interview on 11/2/15, at 3:38 p.m. occupational therapist (OTR)-A and OTR-B, stated the occupational therapy department did not complete assessments for residents to determine whether they were able to safely smoke independently, they stated nursing completed the Smoking Safety Evaluation. OTR-A stated if a resident indicated they wanted to smoke, nursing could refer them to the occupational therapy (OT) department and they would assess a resident's physical capability of that activity however, OT would not determine whether a resident was able to smoke safely independently. OTR-A stated OT would review a resident for their ability to open a pack of cigarettes, use a lighter appropriately, assess if the resident had the ability to independently bring the cigarette to their mouth, assess if the resident was able to "ash" a cigarette and extinguish the cigarette safely, and if the resident had the ability to brush off ashes if the resident were to drop the cigarette on themselves. OTR-B reviewed R53's OT notes, and stated in September 2015, another occupational therapist had worked with R53. OTR-B stated OT had worked with R53 on utilizing a "U-Cuff" (a device that wraps around the residents hand to assist in using items such as spoons, pencils, and other items that could be placed for self use) to assist the resident with grasping and working in coordination for self cares. However, OTR-A stated OT only assessed the physical ability of a resident, and did not assess a resident's ability to smoke

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safety.

During interview on 11/2/15, at 4:00 p.m. the administrator stated staff had not reported R53 had any cigarette burn holes in the fleece blanket she laid on her lap. The administrator stated she expected staff would monitor any resident who smoked for burns or burn holes in clothes, and if noted, they should notify nursing and/ or administrator of concerns.

During interview on 11/2/15, at 4:11 p.m. NA-A stated a couple of weeks ago R53 received an electric wheelchair. NA-A stated that prior to receiving the electric wheelchair, the resident had been using a standard wheelchair and was unable to propel herself to go out to the smoking area independently, so R53 would request staff assistance with going outside to the designated smoking area. NA-A stated staff would bring R53 outside to the smoking area, ask R53 how long she wanted to be outside, and would leave R53 outside to independently smoke while being provided assistance from other residents with smoking. NA-A stated other residents would assist R53 with lighting her cigarette, and NA-A stated staff had not been directed that R53 was unsafe to smoke without staff supervision. NA-A stated since R53 received the electric wheelchair, she was now able to independently go outside to smoke without having to ask for staff to wheel her outside. NA-A stated she had not been instructed R53 was unable to safely smoke without staff supervision, nor was NA-A aware R53 had cigarette burn holes in the fleece lap blanket.

During interview on 11/2/15, at 4:22 p.m. registered nurse (RN)-B stated she was not aware if R53 had any concerns of burns since

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being at the facility, nor was RN-B aware R53 had cigarette burn holes in her fleece blanket. RN-B did not have any specific safety concerns related to R53 smoking independently.

During interview on 11/2/15, at 5:50 p.m. the director of nursing (DON) stated she believed, according to R53's Safe Smoking Evaluation, R53 was safe to smoke without staff supervision, and the resident was working with OT to ensure safe smoking. The DON stated staff were only directed to monitor R53 for continued, independent, safe smoking however, staff were not directed to remain with R53 when she smoked. Although the Safe Smoking Evaluation completed on 9/16/15, indicated R53 was not able to smoke safely independently, the DON indicated R53 was safe to smoke without staff supervision.

During interview on 11/3/15, at 11:47 a.m. primary occupational therapist (OTR-C), OTR-B (director supervisor), and OTR-D (Rehab Director) stated the facility nursing staff had conferred with OTR-C regarding the Safe Smoking Evaluation completed on 9/16/15, for R53 however, OTR-C stated a therapy goal for smoking was not completed, nor did OT assess R53 regarding her ability to safely smoke independently. OTR-C stated the assessment of a resident's ability to safely smoke independently is the responsibility of nursing. OTR-D reviewed R53's Safe Smoking Evaluation completed by nursing on 9/16/15, and stated she had not been involved in the assessment of R53's smoking, nor did OT provide any of the information on the assessment.

During interview on 11/4/15, at 6:53 p.m. RN-A

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(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 323	Continued From page 11	F 323		

stated she was aware of the burn hole(s) in R53's fleece blanket, and believed the cigarette holes had been there a few months. RN-A stated she was aware R53 was unable to hold a cigarette and required assistance from peers to obtain and light a cigarette, and staff did not supervise or provide assistance to R53 when smoking.

During interview on 11/5/15, at 1:34 p.m. RN-G stated Safe Smoking Evaluations were completed by nursing by gathering information from residents related to how much they smoke however, when RN-G acknowledged when she'd updated smoking assessments on 11/2/15, for the 6 residents who smoke in the facility, she did not observe them smoking to ensure safety. RN-G also stated R53's Smoking Safety Evaluation was not updated on 11/2/15.

An undated facility document titled, My Room Rules & Regulations indicated, "Smoking is discouraged due to its many health risks. If you smoke, you are asked to smoke only in the designated area outside the building. Staff and visitors are not allowed to smoke on Courage Center property."

The facility policy titled Smoking effective date 3/9/99, with a revision date of 11/3/15, did not address resident safety related to smoking, nor did it identify how the facility would determine if a resident was able to safely smoke independently.

The immediate jeopardy that began on 11/2/15, at 5:50 p.m. was removed on
11/5/15, at 9:54 a.m. when the facility completed the following interventions:

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 _____	11/05/2015

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

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F 323	Continued From page 12 - Staff completed an updated Safe Smoking Evaluation for R53 which directed staff the resident required staff supervision when smoking. - R53's care plan was updated indicating R53 was not safe to smoke independently, and required staff assistance/ supervision when smoking. - All staff, as well as R53's family members, were educated to ensure R53 was provided supervision when smoking. - The facility implemented a Wanderguard (an electronic device that will alarm when going out of the facility) for R53, which would ensure staff was aware when the resident was going out to smoke so staff could supervise the resident to ensure safety when smoking. The facility interviewed R53 regarding using a Wanderguard, and the resident agreed to wear the Wanderguard and did not feel there were any violation to her rights related to the Wanderguard. On 11/4/15, from 1:34 p.m. to 6:53 p.m., and 11/5/15, from 7:26 a.m. to 9:00 a.m. nursing and direct care staff were interviewed and stated they had received training regarding R53's inability to safely smoke without staff assistance and supervision, and staff were instructed to assist and supervise R53 when smoking, and they were required to stay with R53 when smoking to ensure the resident was safe.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/03/2015**

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. 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 34 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.

Minnesota Department of Health

Electronically delivered
November 20, 2015

Mr. Matthew Kinne, Administrator
Courage Kenny Rehabilitation Institute's Trp
3915 Golden Valley Road
Golden Valley, Minnesota 55422

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5519026

Dear Mr. Kinne:

The above facility was surveyed on November 2, 2015 through November 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner at (320) 223-7343 or email: jessica.sellner@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00751	A. BUILDING: _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE KENNY REHABILITATION INSTITUT	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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 2nd, 3rd, 4th, and 5th, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility to ensure the care plan was implemented for 1 of 7 residents (R53) reviewed for smoking. Findings include: R53's admission Minimum Data Set (MDS) dated 6/4/15, indicated R53 had no cognitive impairment and required extensive staff assistance with all ADLs (activities of daily's living). R53's care area assessment (CAA) dated 6/4/15, indicated the resident had physical limitations including weakness, limited range of motion, and poor coordination with all ADL's. R53's care plan dated 9/16/15, indicated the resident smoked tobacco and staff were directed R53 required staff supervision, or supervision	2 565	Corrected	12/14/15

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2 565	Continued From page 3	2 565		

from another person who could functionally safely assist R53 with smoking. The care plan also directed staff to monitor R53 for cigarette burns and ensure the resident was smoking safety.

During interview on 11/2/15, at 3:00 p.m. R53 stated she was able to go outside in the facility smoking area to smoke independently, and did not need staff assistance or supervision while smoking. R53 stated she carried her cigarettes and lighter with her, and goes outside and another resident would light her cigarette for her. R53 stated she was not able to hold the cigarette with her hands, however she held the cigarette between her teeth and lips, and when she needed to "ash" her cigarette, she turned her head to the side and blows the ashes off. When R53 finished the cigarette, she blew, or spit, out the cigarette onto the ground. R53 stated she had recently dropped a cigarette onto the fleece lap blanket she draped across her lap, and the blanket got a burn hole in. R53 pointed to the lap blanket across her lap which was observed to have two burn holes that went all the way through the blanket; one was the approximate size of a penny, and the other was approximately the size of a number two pencil eraser. The blanket was also observed to have several singed marks on the blanket.

During observation on 11/2/15, at 3:09 p.m. R53 was observed wheeling the electric wheelchair outside into the facility smoking area. R53 asked another resident who was in a motorized wheel chair to obtain her cigarettes out of her backpack. The other resident got a cigarette for R53, put the cigarette into his mouth, lit it, and then placed the lit cigarette into R53's mouth. R53 held the cigarette in between her teeth and lips while

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2 565	Continued From page 4 talking with other residents, and the cigarette was observed moving up and down as she talked. R53 was wearing a knit scarf which was looped around her neck, and had the fleece lap blanket draped across her lap. As R53 smoked, she would turn her head to the right and blew, making a whistling sound, while the ashes were blowing away from R53's end of the cigarette and some of the gray ashes were observed landing on her right arm. When R53 was finished smoking, she spit out the lit cigarette butt on to the ground to the right of her, and another resident attempted to roll over the lit cigarette butt with his wheelchair, however, he missed running it over both times. During interview on 11/4/15, at 6:53 p.m. registered nurse (RN)- A stated according to R53's care plan, the resident should be monitored by staff while smoking for safety, however, staff were not following the care plan. Facility policy on following the plan of care was requested but not received from the facility. SUGGESTED METHOD OF CORRECTION: Director or Nursing and/or designee could educate all staff to the assessed care planned needs of all residents, to assure appropriate and safe care is provided TIME PERIOD FOR CORRECTION: Seven (7) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		12/14/15

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2 830	Continued From page 5 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an individualized smoking assessment which included providing supervision and ensuring safety measures were put into place for 1 of 7 residents (R53) who currently smoked unsupervised at the facility. This resulted in immediate jeopardy (IJ) for R53 who was at risk of serious injury when the facility failed to ensure a comprehensive Smoking Safety Assessment was completed, and interventions were implemented to ensure the resident was safe to smoke unsupervised. The immediate jeopardy began on 9/16/15, when R53's Smoking Safety Evaluation identified R53 was not able to safely utilize lighter/matches, was unable to safely handle lit smoking material, and indicated, "Client is unable to smoke outside independently due to physical function." However, R53 was observed smoking independently and was receiving assistance from	2 830	Corrected	

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2 830	Continued From page 6 other residents with no staff present, and was also observed to have cigarette burn holes in the fleece blanket that covered her lap. On 11/2/15, at 5:50 p.m. the administrator and director of nursing (DON) were notified of the IJ for R53. The IJ was removed on 11/5/15, at 9:54 a.m. but noncompliance remained at an isolated scope and severity level, which indicated potential for actual harm that is not an immediate jeopardy. Findings include: R53's admission Minimum Data Set (MDS) dated 6/4/15, indicated R53 had no cognitive impairment, and required total staff assistance for bed mobility, transfers, dressing, personal hygiene, and toileting. The MDS indicated R53 had diagnoses including quadriplegia (paralysis resulting in partial or total loss of use of the limbs), anxiety, and muscle weakness. R53's Care Area Assessment (CAA) dated 6/4/15, indicated R53 had physical limitations including weakness, limited range of motion, and poor coordination with all activities of daily living (ADL's). R53's care plan dated 9/16/15, indicated R53 smoked tobacco, and instructed staff the resident required staff supervision, or supervision from another person who could functional safely to assist R53 with smoking, however, the care plan did not identify if this was family, friends, and/or other residents in the facility. The care plan also directed staff to monitor R53 for cigarette burns and ensure the resident was smoking safely. R53's Smoking Safety Evaluation dated 9/16/15, indicated R53 smoked 3-4 times a day, had been observed during smoking, and the resident did	2 830		

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2 830	Continued From page 7 not always smoke in the designated smoking area indicating, "There are times when client is seen smoking outside of building close to trees outside of facility, which is not near the designated smoking area." The Smoking Safety Evaluation also identified the resident was not able to safely utilize lighter/ matches, could not safely handle lit smoking material, did not use/wear appropriate safety devices, had no holes in clothing or belongings, and therapy had reviewed resident's physical function related to smoking. The evaluation summary of the data collection indicated, "Client was not smoking upon admission to the facility, but did start smoking again with other clients. One client noted to be assisting her with smoking and other friends of client have been assisting her with this. Client is unable to smoke outside independently due to physical function. Client does not sit with cigarette in her mouth or hold cigarette in her hand independently. Client has had assistance with this. Client has been safe with smoking thus far. Smoking apron has been ordered by administrator for safety." Although the Smoking Safety Evaluation indicated the resident was not able to safely utilize lighter/ matches, and could not safely handle lit smoking material, there was no further assessment to determine how the facility would ensure R53 would be kept safe when smoking. During interview on 11/2/15, at 1:59 p.m. R53 stated she was able to go outside independently and received assistance from other residents to smoke. R53 stated she required assistance to smoke and would have another resident place a cigarette in her mouth and light it for her, and that she would hold the cigarette between her teeth and lips, and would turn her head when she needed to ash the cigarette. R53 stated when	2 830		

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2 830	Continued From page 8 she was done with the cigarette, she would turn her head to the side and "blow" the cigarette out of her mouth onto the ground, as she is not able to use her hands/arms to hold the cigarette. R53 stated she did not wear a smoking apron, nor was she instructed by the facility she was required to use or wear any specialized equipment when smoking. During interview on 11/2/15, at 2:55 p.m. nursing assistant (NA)-D stated R53 kept her cigarettes and lighter with her in her backpack. NA-D stated she was not aware R53 had any safety concerns with smoking, and stated staff were not instructed the resident needed to be supervised when smoking. During a follow up interview on 11/2/15, at 3:00 p.m. R53 stated she'd recently obtained a burn hole from a cigarette she had dropped on a fleece blanket she had laid across her lap. R53 stated she'd gotten the blanket when she was admitted to the facility, and verified she started to smoke shortly after her admission. R53 stated she was able to go outside and smoke without staff supervision, and received assistance from other residents or friends to obtain, and light her cigarettes. R53 stated her peers would assist her with lighting the cigarette, and at times they would go back into the facility because once the cigarette was lit, she was able to stay outside alone and finish her cigarette. R53 was observed with a fleece blanket laying across her lap which had two burn holes that went all the way through the blanket. One of the burn holes was approximately the size of a penny, and the other was approximately the size of a number two pencil eraser. The fleece blanket was also observed to have multiple singed marks.	2 830		

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	00751	A. BUILDING: _____ B. WING _____	11/05/2015

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COURAGE KENNY REHABILITATION INSTITUT	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) COMPLETE DATE
2 830	Continued From page 9 During observation on 11/2/15, at 3:09 p.m. R53 was observed outside the facility in the designated smoking area smoking a cigarette. There were no staff present outside. R53 asked another resident in a motorized wheel chair to obtain a cigarette out of her backpack and light it for her. The other resident got a cigarette out of R53's backpack, placed it into his mouth and lit it, and then placed the lit cigarette into R53's mouth. R53 held the cigarette between her teeth and lips, and while she was talking with other residents the cigarette was moving up and down in her mouth. R53 was wearing a knit scarf which was looped around her neck, had the fleece blanket laying over her lap, and was not wearing a smoking apron nor did she have any other smoking safety device(s) in place. During observation of R53 smoking, she would turn her head to the right, and blow, making a whistling sound, to get the ashes off the end of the cigarette. Some of the gray ashes were observed landing on R53's right arm. When R53 finished the cigarette, she turned her head to the right, and spit/ blew the cigarette out of her mouth onto the ground. Another resident in a wheelchair attempted to roll over the lit cigarette to put it out however, the resident was unable to extinguish the cigarette after attempting to roll over it two times and missing the cigarette. During interview on 11/2/15, at 3:38 p.m. occupational therapist (OTR)-A and OTR-B, stated the occupational therapy department did not complete assessments for residents to determine whether they were able to safely smoke independently, they stated nursing completed the Smoking Safety Evaluation. OTR-A stated if a resident indicated they wanted to smoke, nursing could refer them to the occupational therapy (OT) department and they	2 830		

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2 830	Continued From page 10	2 830		

would assess a resident's physical capability of that activity however, OT would not determine whether a resident was able to smoke safely independently. OTR-A stated OT would review a resident for their ability to open a pack of cigarettes, use a lighter appropriately, assess if the resident had the ability to independently bring the cigarette to their mouth, assess if the resident was able to "ash" a cigarette and extinguish the cigarette safely, and if the resident had the ability to brush off ashes if the resident were to drop the cigarette on themselves. OTR-B reviewed R53's OT notes, and stated in September 2015, another occupational therapist had worked with R53. OTR-B stated OT had worked with R53 on utilizing a "U-Cuff" (a device that wraps around the residents hand to assist in using items such as spoons, pencils, and other items that could be placed for self use) to assist the resident with grasping and working in coordination for self cares. However, OTR-A stated OT only assessed the physical ability of a resident, and did not assess a resident's ability to smoke safety.

During interview on 11/2/15, at 4:00 p.m. the administrator stated staff had not reported R53 had any cigarette burn holes in the fleece blanket she laid on her lap. The administrator stated she expected staff would monitor any resident who smoked for burns or burn holes in clothes, and if noted, they should notify nursing and/ or administrator of concerns.

During interview on 11/2/15, at 4:11 p.m. NA-A stated a couple of weeks ago R53 received an electric wheelchair. NA-A stated that prior to receiving the electric wheelchair, the resident had been using a standard wheelchair and was unable to propel herself to go out to the smoking

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2 830	Continued From page 11	2 830		

area independently, so R53 would request staff assistance with going outside to the designated smoking area. NA-A stated staff would bring R53 outside to the smoking area, ask R53 how long she wanted to be outside, and would leave R53 outside to independently smoke while being provided assistance from other residents with smoking. NA-A stated other residents would assist R53 with lighting her cigarette, and NA-A stated staff had not been directed that R53 was unsafe to smoke without staff supervision. NA-A stated since R53 received the electric wheelchair, she was now able to independently go outside to smoke without having to ask for staff to wheel her outside. NA-A stated she had not been instructed R53 was unable to safely smoke without staff supervision, nor was NA-A aware R53 had cigarette burn holes in the fleece lap blanket.

During interview on 11/2/15, at 4:22 p.m. registered nurse (RN)-B stated she was not aware if R53 had any concerns of burns since being at the facility, nor was RN-B aware R53 had cigarette burn holes in her fleece blanket. RN-B did not have any specific safety concerns related to R53 smoking independently.

During interview on 11/2/15, at 5:50 p.m. the director of nursing (DON) stated she believed, according to R53's Safe Smoking Evaluation, R53 was safe to smoke without staff supervision, and the resident was working with OT to ensure safe smoking. The DON stated staff were only directed to monitor R53 for continued, independent, safe smoking however, staff were not directed to remain with R53 when she smoked. Although the Safe Smoking Evaluation completed on 9/16/15, indicated R53 was not able to smoke safely independently, the DON indicated R53 was safe to smoke without staff

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2 830	Continued From page 12 supervision. During interview on 11/3/15, at 11:47 a.m. primary occupational therapist (OTR-C), OTR-B (director supervisor), and OTR-D (Rehab Director) stated the facility nursing staff had conferred with OTR-C regarding the Safe Smoking Evaluation completed on 9/16/15, for R53 however, OTR-C stated a therapy goal for smoking was not completed, nor did OT assess R53 regarding her ability to safely smoke independently. OTR-C stated the assessment of a resident's ability to safely smoke independently is the responsibility of nursing. OTR-D reviewed R53's Safe Smoking Evaluation completed by nursing on 9/16/15, and stated she had not been involved in the assessment of R53's smoking, nor did OT provide any of the information on the assessment. During interview on 11/4/15, at 6:53 p.m. RN-A stated she was aware of the burn hole(s) in R53's fleece blanket, and believed the cigarette holes had been there a few months. RN-A stated she was aware R53 was unable to hold a cigarette and required assistance from peers to obtain and light a cigarette, and staff did not supervise or provide assistance to R53 when smoking. During interview on 11/5/15, at 1:34 p.m. RN-G stated Safe Smoking Evaluations were completed by nursing by gathering information from residents related to how much they smoke however, when RN-G acknowledged when she'd updated smoking assessments on 11/2/15, for the 6 residents who smoke in the facility, she did not observe them smoking to ensure safety. RN-G also stated R53's Smoking Safety Evaluation was not updated on 11/2/15.	2 830		

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2 830	Continued From page 13 An undated facility document titled, My Room Rules & Regulations indicated, "Smoking is discouraged due to its many health risks. If you smoke, you are asked to smoke only in the designated area outside the building. Staff and visitors are not allowed to smoke on Courage Center property." The facility policy titled Smoking effective date 3/9/99, with a revision date of 11/3/15, did not address resident safety related to smoking, nor did it identify how the facility would determine if a resident was able to safely smoke independently. The immediate jeopardy that began on 11/2/15, at 5:50 p.m. was removed on 11/5/15, at 9:54 a.m. when the facility completed the following interventions: - Staff completed an updated Safe Smoking Evaluation for R53 which directed staff the resident required staff supervision when smoking. - R53's care plan was updated indicating R53 was not safe to smoke independently, and required staff assistance/ supervision when smoking. - All staff, as well as R53's family members, were educated to ensure R53 was provided supervision when smoking. - The facility implemented a Wanderguard (an electronic device that will alarm when going out of the facility) for R53, which would ensure staff was aware when the resident was going out to smoke so staff could supervise the resident to ensure safety when smoking. The facility interviewed R53 regarding using a Wanderguard, and the resident agreed to wear the Wanderguard and did	2 830		

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2 830	Continued From page 14 not feel there were any violation to her rights related to the Wanderguard. On 11/4/15, from 1:34 p.m. to 6:53 p.m., and 11/5/15, from 7:26 a.m. to 9:00 a.m. nursing and direct care staff were interviewed and stated they had received training regarding R53's inability to safely smoke without staff assistance and supervision, and staff were instructed to assist and supervise R53 when smoking, and they were required to stay with R53 when smoking to ensure the resident was safe. SUGGESTED METHOD OF CORRECTION: The facility administrator and/or designee could review smoking safety assessment process to staff responsible, and educate ALL staff who have direct contact with smoking residents to what is accetible smoking practice TIME PERIOD FOR CORRECTION: One (1) day.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of	21426		12/14/15

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21426	Continued From page 15 Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and documentation review, the facility failed to document millimeters (mm) of induration for the tuberculin skin test (TST) for 1 of 5 residents (R84), and failed to date a symptom screen for 1 of 5 residents (R12), who were reviewed for tuberculosis testing. Findings include: R84's first step TST was given 9/2/15, and was documented as positive, however, the documentation did not include any date, nor was the millimeters of induration documented. R12's tuberculosis symptom screen was located in the resident's medical record, however, the symptom screen was undated, and the facility was unable to provide any documentation regarding when this was completed. During interview on 11/5/15, at 2:06 p.m. director of nursing (DON) stated staff should be dating the symptom screen to ensure it was done timely, and also document the millimeters of induration when reading a TST test. The facility's Tuberculin Control dated 8/14	21426	Corrected	

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21426	Continued From page 16 indicated if induration is present, measure the diameter of induration perpendicular to the long axis of the forearm and record the diameter in mm of induration. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could provide education for staff regarding resident tuberculosis screening and testing. The DON and/or designee could do random audits to ensure compliance.	21426		