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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RXVB

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** **55422**
(L6)

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 **11/12/2014** (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 **40** (L18)

13.Total Certified Beds **40** (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
	40			
(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 :
Mary Rogers, HPR Social Work Specialist 11/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 11/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/02/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/05/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245519
Electronically Delivered
November 17, 2014

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 November 10, 2014 the above facility is certified for or recommended for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 17, 2014

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

RE: Project Number S5519025

Dear Mr. Kinne:

On October 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 1, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On October 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 1, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 1, 2014, effective November 10, 2014 and therefore remedies outlined in our letter to you dated October 14, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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	11/12/2014

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 **F0167** Reg. # **483.10(g)(1)** LSC	**11/10/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	**11/10/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**11/10/2014**
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	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	JS/KJ	11/17/2014	29437	11/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
10/1/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RXVB

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 **10/01/2014** (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 **40** (L18)

13.Total Certified Beds **40** (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
	40			
(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 10/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/05/2014 (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)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 14, 2014

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

RE: Project Number S5519025

Dear Mr. Kinne:

On October 1, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the

attached deficiencies.

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 10, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

- Include dates when corrective action will be completed. The corrective action

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 1, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 1, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING _____ B. WING _____	10/01/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post the most recent federal and state survey results in a place readily accessible to residents and indicate a notice of availability of the survey results so they could be located. This had the potential to affect all 34 residents currently residing in the facility.	F 167	F Tag 167 Examination of Survey Results It is the policy of Courage Kenny Transitional Rehabilitation Program that a client has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with	11/10/14

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

Electronically Signed | 10/24/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING _____ B. WING _____	10/01/2014

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 167	Continued From page 1 Findings include: During initial tour of the facility on 9/29/14, at 1:05 p.m. the most recent federal and state survey results were observed in a clear, unlabeled plastic sleeve which was hanging from a bulletin board by the laundry room door located on the ground floor, and at the end of the hall on the first floor. The bulletin boards were located down the opposite hallway of the elevator and main traffic area, and were not near the nurse's station, entrances to the facility, or in an area where residents frequent. There was no information that identified what was inside the plastic sleeve, nor was there any posting to inform residents the availability of the facility's survey results anywhere in the facility. Resident (R91) Admission Minimum data set (MDS) dated 8/13/14, identified R91 was cognitively intact. During interview on 9/29/14, at 4:00 p.m. R91 stated she was not sure where the survey results were located, and walked out of her room into the hallway to look at information posted on a bulletin board down the hallway. Although the survey results were hanging in the plastic sleeve on the bulletin board, R91 was unable to identify the unlabeled sleeve containing the survey results and stated, "Nope, not here." R16's quarterly MDS dated 7/9/14, identified R16 was cognitively intact. During interview on 9/29/14, at 4:35 p.m. R16 stated she did not know where the survey results were located in the facility.	F 167	respect to the facility. The recent survey results were located on a bulletin board in the hallway at the time of the survey and currently, and placed an additional copy in a binder (located at the nurses station) to be readily available and accessible to our clients by 11/10/14. A posting directing clients to the location of the past survey results was placed on the bulletin board on 10/7/14. Staff education was and will be provided and completed regarding the posting of survey results and their accessibility on 10/23/14 and 11/10/14. For other clients who may be affected by this practice the survey results are located on the bulletin board (near the laundry room) and placed in a binder (located at the nurses station) and a memo identifying locations to survey locations to all clients will be delivered by 11/10/14. The information in the admission packet includes this location. The protocol/practice of posting the survey results was reviewed by the leadership team on 10/23/14. Staff members were trained as it relates to their respective roles and responsibilities for the revised policy and procedure by 11/10/14. Rounds will be completed monthly for 12 months, and on-going random inspections will be completed to visually check that the survey results are in the designated location per policy with results reported to the QA/QI Committee for review and further recommendation. Upon review system revisions and/or staff education	

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	245519	A. BUILDING _____ B. WING _____	10/01/2014

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F 167	Continued From page 2 R71 admission MDS dated 6/23/14, identified R71 had moderate cognitive impairment. During interview on 9/29/14, at 7:36 p.m. R71 stated he did not know where the facility survey results were located. R3 admission MDS dated 9/5/14, identified R3 had no cognitive impairment. During interview on 9/29/14, at 7:00 p.m. R3 stated she did not know if the facility had survey results available, and was not sure where to look for them. During interview on 9/30/14, at 9:24 a.m. Health Unit Coordinator (HUC) stated she was not aware where the facility posted the survey results. During interview on 9/30/14, at 9:33 a.m. director of nursing (DON) stated there was no notice posted to inform residents where the state survey results were posted. DON verified residents would need to ask if they wanted to see the survey results due to the lack of posting in a visible site, and there was no sign indicating to residents where they could find the most recent survey. A review of the facility's policy titled Residents' Bill of Rights dated 8/20/01, included "Inspection findings of state and local health authorities are posted on both floors and available to participants, their guardians or chosen representative upon request to the Administrator."	F 167	will be implemented if indicated by a prescribed corrective action plan. The Administrator/Director of Nursing or designee will be responsible for compliance. Date of Correction: 11/10/14	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	F 247		11/10/14

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F 247	Continued From page 3 A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure appropriate notice of a room change was provided prior to a room change for 1 of 2 residents (R101) reviewed for admission, transfer, and discharge. Findings include: R101's admission Minimum Data Set (MDS) dated 9/10/14, identified R101 had no cognitive impairment. During interview on 9/29/14, at 7:43 p.m. R101 stated she had been moved to a different room in the facility during the past month, however, the facility did not let her know she was going to be moving prior to the room change. R101's Progress notes dated 9/15/14, at 10:28 p.m. indicated R101 had been moved to another room earlier that day. During interview on 9/30/14, at 1:15 p.m. utilization and management associate (UMA)-A, who works in the admissions at the facility, stated residents are notified prior to a room change either seven days in advance, or sooner if it is medically needed. During another interview on 10/1/14, at 8:03 a.m. UMA-A stated the nurse who talked with R101	F 247	F Tag 247 Accommodation of Needs It is the policy of Courage Kenny Transitional Rehabilitation Program that clients receive notice before a room change in the facility. For client #101 a notice of room change was completed and delivered to the client/responsible party on 10/22/14. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the client and/or designated decision maker. Education/counseling was provided for staff members regarding notice of room change and will be completed by 11/10/14. For other clients who may be affected by this practice a record review was completed regarding Room Transfer Notification on 10/24/14. Upon completion of the review, corrections or revisions were made as needed. The policy and procedure for Room Transfer Notification was reviewed by the interdisciplinary team on 10/23/14. The Medical Director reviewed the policy to ensure it meets the current standards of practice. Education will be provided for staff members by 11/10/14 regarding	

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F 247	Continued From page 4 should have filled out a written transfer form and placed it in R101's chart. UMA-A verified there was no transfer documentation regarding R101's room change and notification prior to the room change. The facility policy titled Resident Rights, Transfer, and Discharge dated 8/20/01, indicated if a residents room is changed, the facility must give seven days advance notice in writing prior to room change.	F 247	Room Transfer Notification as it relates to their respective roles and responsibilities for the reviewed and revised policies and procedures. Audits will be completed weekly for 8 weeks, monthly for 12 months, and then on-going random audits to ensure that notice is issued to clients in advance of room change with results reported to the QI/QA Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan. The Administrator/Director of Nursing or designee will be responsible for compliance. Date of Correction: 11/10/14	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		11/10/14

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F 431	Continued From page 5 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl (narcotic analgesic) patches were destroyed in a manner to prevent potential diversion for 4 of 4 residents (R103, R12, R102, and R98) receiving Fentanyl patches, and failed to ensure employees were educated and were following facility policy regarding Fentanyl destruction. Findings include: A review of the facility policy titled, Disposal of Medications and Medication-Related Supplies dated 6/2/14, instructed, "When a dose of a controlled medication is removed ...It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability	F 431	F Tag 431 Service Consultation It is the policy of Courage Kenny Transitional Rehabilitation Program to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Education/counseling was provided for staff members regarding Disposal of Medications/ Destruction of used Fentanyl Patches including controlled substances on 10/1/14.	

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F 431	Continued From page 6 record/book ...The same applies to the disposal of ...doses of controlled substances wasted for any reason... Disposition is documented on the individual controlled substance accountability book." A review of a facility Internal Memo dated 4/26/13, instructed staff, "Effective immediately, please follow these steps when administering and removing Fentanyl patches. These steps are in place to prevent drug diversion, which is a growing problem with Fentanyl patches ...Have a second nurse observe while the patch is flushed into the sanitary system. Both nurses sign the narcotic destruction log for destruction of the medication." R103's diagnoses on the face sheet dated 9/9/14, included paraplegia, muscle weakness, and disturbance of skin sensation. R103's physician order summary report for 9/1/14, through 9/30/14, included, "Fentanyl patch, 72 hour, 100 mcg/hr [micrograms/hour] apply one patch transdermally [placed on the skin] one time a day every 3 day(s) for pain and remove per schedule." R103's Medication Administration Record (MAR) dated 9/14, included one staff 's initials for removing a patch off R103, and had the same employee initials for applying a new Fentanyl patch. The MAR lacked documentation of two nurse witness signatures/initials indicating the proper disposal of the Fentanyl patches according to facility policy. R12's diagnoses on the face sheet dated 5/12/14, included difficulty walking, muscle weakness, malaise and fatigue. R12's physician orders, dated 9/26/14, included, "Fentanyl patch, 75 mcg/hr 72 hr. Apply [one] patch daily q [every] 3 days, and remove as ordered for pain." R12's	F 431	Client #12, discharged 10/17/14. For other clients who may be affected by this practice a record review was completed regarding disposal of medication/destruction of Fentanyl patches on 10/1/14. Clients with use of Fentanyl Patches were identified by chart review. The policy and procedure for Disposal of Medications and Medication-Related Supplies was reviewed and revised by the interdisciplinary team on 10/9/14. A review of policies by the Medical Director will be completed by 11/10/14 to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding Disposal of Medication/ Destruction of used Fentanyl Patches by 11/10/14. Pharmacy audits will be completed weekly for 8 weeks, monthly for 12 months, and then on-going random audits to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 11/10/14.	

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F 431	Continued From page 7 MAR dated 9/14, included one staff 's initials for removing a patch, and the same initials for applying the new Fentanyl patch. The MAR lacked documentation of two nurse witness signatures/initials indicating the proper disposal of the Fentanyl patches according to facility policy. R102's diagnoses on the face sheet dated 9/29/14, included C5-C7 (cervical spine) level with central cord syndrome. R102's physician order summary report for 9/1/14, through 9/30/14, included, "Fentanyl patch, 72 hour, 12 mcg/hr. Apply 1 patch transdermally, one time a day every 3 day(s) for pain, and remove per schedule." R102's MAR dated 9/14, included one staff's initials to indicate a Fentanyl patch was applied on 9/30/14. The MAR lacked documentation of two nurse witness signatures/initials indicating the proper disposal of the Fentanyl patches according to facility policy. R98's diagnoses on the face sheet dated 8/25/14, included quadriplegia and cervical spine fracture. R98's physician order summary report for 9/1/14, through 9/30/14, included, "Fentanyl patch, 72 Hour 25 mcg/hr., Apply 1 patch transdermally every 72 hours for pain, apply to dry, clean, hairless skin and remove per schedule." R98's MAR dated 9/14, included only one staff 's initials for removing a patch, and the same initials for applying the new Fentanyl patch. The MAR lacked documentation of two nurse witness signatures/initials indicating the proper disposal of the Fentanyl patches according to facility policy. During interview on 9/29/14, at 5:25 p.m. licensed practical nurse (LPN)-A and registered nurse (RN)-A, both stated when they removed a Fentanyl patch from a resident, they would flush it	F 431		

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F 431	Continued From page 8 down the toilet, with a second nurse as a witness. When asked where they document the destruction of the patch(s) with two nurses, both stated they didn't document it anywhere, adding they were not sure where they would do that in the electronic record. During interview on 9/29/14, at 6:01 p.m. RN-B stated when she removed a Fentanyl patch from a resident she would wrap it in toilet paper and flush it down the toilet. RN-B stated the facility required 2 staff to destroy Fentanyl patches, however, staff did not document if there was a second staff member during destruction. During interview on 9/30/14, at 9:33 a.m. director of nursing (DON) verified the facility did not have a system in place to document and ensure two staff were involved in the destruction of the Fentanyl patches when they were removed from a resident according to facility policy. During interview on 10/1/14, at 12:41 p.m. the facility's pharmacy consultant (PC)-A stated Fentanyl patches should be destroyed by wrapping it in a tissue and flushing it down the toilet, with two nurses involved. Both nurses who were involved in the disposal of the Fentanyl patch should be documenting the destruction in the residents electronic medical record. PC-A stated she was not aware staff were not documenting the destruction and witnessing of the Fentanyl patches, and the facility should be following their policy for Fentanyl destruction.	F 431		

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	245519	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/01/2014**

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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 40 beds and had a census of 38 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.