DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 25, 2026

Administrator
Courage Kenny Rehabilitation Institutes
3915 Golden Valley Road
Golden Valley, MN 55422

RE: CCN: 245519
Cycle Start Date: April 13, 2026

Dear Administrator:

On April 30, 2026, we notified you a remedy was imposed.

On May 21, 2026, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 11, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 15, 2026, did not go into effect. (42 CFR 488.417 (b)).

In our letter of April 30, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 13, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 25, 2026

Administrator
Courage Kenny Rehabilitation Institutes
3915 Golden Valley Road
Golden Valley, MN 55422

Re: Reinspection Results
Event ID: 22D713-H2

Dear Administrator:

On May 21, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 13, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

April 30, 2026

Administrator
Courage Kenny Rehabilitation Institutes
3915 Golden Valley Road
Golden Valley, Mn 55422

RE: CCN: 245519
Cycle Start Date: April 13, 2026

Dear Administrator:

On April 13, 2026, survey was completed at your facility by the Minnesota Department of Health 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.

REMOVAL OF IMMEDIATE JEOPARDY

On April 9, 2023, the situation of immediate jeopardy to potential health and safety cited at F0689: Free of Accident Hazards/Supervision/Devices was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 15, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 15, 2026 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 15, 2026, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 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 $13,343; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 13, 2026. This prohibition is not subject to appeal. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control 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 Institutes Trp is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 13, 2026. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 October 13, 2026 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, 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 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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 & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP 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. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 30, 2026

Administrator
Courage Kenny Rehabilitation Institutes
3915 Golden Valley Road
Golden Valley, Mn 55422

Re: State Nursing Home Licensing Orders
Event ID: 22D713-H1

Dear Administrator:

The above facility survey was completed on April 13, 2026, 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	**3915 GOLDEN VALLEY ROAD , GOLDEN VALLEY, Minnesota, 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
F0000	INITIAL COMMENTS On 4/7/26 – 4/13/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H55191093C/MN2971520 with a deficiency issued at F689. Deficient practice was identified related to incidental finding at F550, F604, F657, F846, and F909. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to identify environmental risks for stairwell doors that had nonfunctioning alarms, disabled locks, and failed to adequately supervise 1 of 3 residents (R1) through the remote monitoring system. This resulted in immediate jeopardy for 1 of 3 residents (R1) reviewed who opened a stairwell access door, wheeled through the door, and fell six stairs while secured by a lap belt in his wheelchair. R1 sustained a hematoma (localized collected of clotted or partially clotted blood outside causing swelling, pain, and skin discoloration) and was sent to the emergency department for evaluation. The above findings constituted substandard quality of care, and an extended survey was conducted from 4/9/26 to 4/13/26. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F0000		05/11/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	**3915 GOLDEN VALLEY ROAD , GOLDEN VALLEY, Minnesota, 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
F0000	Continued from page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		05/11/2026
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to identify environmental risks for stairwell doors that had nonfunctioning alarms, disabled locks, and failed to adequately supervise 1 of 3 residents (R1) through the remote monitoring system. This resulted in immediate jeopardy for 1 of 3 residents (R1) who opened a stairwell access door, wheeled through the door, and fell down six stairs while secured by a lap belt in his wheelchair. R1 sustained a hematoma (localized collected of clotted or partially clotted blood outside causing swelling, pain, and skin discoloration) and was sent to the emergency department for evaluation. In addition, the facility failed to have a system in place for routine checks on the fire door alarm system to ensure the employee badges and the resident wander guard (an alarm placed on or near the resident's body to alarm when they attempt to leave the unit) were in working order. This had the potential to affect all residents who resided in the unit. The Immediate Jeopardy (IJ) began on 4/1/26 when R1 fell down the facilities stairwell. The Administrator and the director of nursing were notified of the immediate jeopardy on 4/7/26 at 5:15 p.m. The immediate jeopardy was removed on 4/9/23 at 5:43 p.m., but noncompliance remained at the lower scope and severity, level 2, F – widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F0689	Courage Kenny Rehabilitation Institute - TRP ensures that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. R1 has discharged from the facility. The facility has compiled a list of residents at risk for wandering or elopement. On 4/7/26 facility identified two stairwell doors as potential accident hazards. On 4/7/26 at 1704 the southeast stairwell door was locked by Security to only allow badge access egress or 15 second push-bar egress with alarm. On 4/7/26 an interim plan was developed and initiated for the stairwell door near the elevator to be secured until the work could be completed to mirror the functionality of the southeast stairwell door. That work was completed 4/21/26. On 4/9/26 staff were re-educated regarding the escalation process for when doors are not functioning as expected. Staff who have not completed the education by the completion date will complete it prior to beginning their next scheduled shift. The Patient and Visitor Safety Event Reporting policy and procedure was reviewed and no changes were necessary. Weekly testing of Wander Guard transmitters has been added to the Wander Guard order set in the electronic medical record. Monthly testing of fire alarm release features is part of the monthly fire drill procedure. Monthly tests of the Wander Guard system have been added to the preventive maintenance plan. Annual service of the Wander Guard system batteries has been added to the preventive maintenance plan. The Administrator or designee will conduct weekly audits to ensure proper functioning of the stairwell doors. Audits will continue until the 5/28/26 QAPI meeting.	05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	**3915 GOLDEN VALLEY ROAD , GOLDEN VALLEY, Minnesota, 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
F0689 SS = SQC-J	Continued from page 2 Findings include: Video surveillance of the incident on 4/1/26 at 4:06 p.m. showed R1 was coming out of his room in his wheelchair headed toward the emergency exit door. He pushed open the door with his left arm, going through the door placed both hands on either the brakes on his wheelchair or the arm rests then the emergency door closed. Two staff were walking into the nursing station office at 4:08 p.m. At 4:12 p.m. the staff walked to the emergency door, opened the door, and appeared to be calling for help. The video surveillance had no auditory recording. Upon observation and interview on 4/7/26 at 12:17 p.m. R1 was seated in his wheelchair in his room with a 1:1 staff. R1 recalled the fall stating he fell down about seven steps, but that is all he could remember. He did not recall whether he was in his wheelchair or not. Upon observation and interview with the maintenance engineer on 4/7/26 at 1:45 p.m. the maintenance engineer used his employee key card to open the door to observe the stairwell where R1 fell. The door opened to six stairs going down and stairs going up. After viewing the stairwell, the surveyor pushed onto the door, the door opened with no alarm sounding or badge use. The maintenance engineer stated that it was a concern, and he would be bringing it up at the following intradisciplinary team meeting the following day. He stated he was not aware that R1 had gotten through the door and fallen down the stairs. He was going to speak with his supervisor, who was at another location and see if he should secure the door until the facility could fix the alarm. R1's consent to remote observation dated 3/11/26 indicated R1 would be monitored remotely via a remote observation video and audio device that is monitored 24 hours a day by a trained observation technologist within the facilities health system. R1's admission Minimum Data Set (MDS) dated 3/18/26, indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was	F0689	Continued from page 2 The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	**3915 GOLDEN VALLEY ROAD , GOLDEN VALLEY, Minnesota, 55422**

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F0689 SS = SQC-J	Continued from page 3 always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke. R1's care plan dated 3/23/26 indicated R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. R1's care plan did not include staff supervision until 4/1/26 following his fall. R1's care plan did not include R1 had a wander guard. R1's provider orders dated 4/1/26 indicated to discontinue the remote observation and start hourly rounding. R1's post-fall summary undated, indicated staff responded to a wander guard at the stairs, found R1 face down in the stairs with his wheelchair attached. R1 hit his head with a hematoma (a localized collection of clotted or pooled outside blood vessels caused by trauma, surgery or underlying vascular injury) forming. Emergency medical services were called and R1 was transferred to the hospital. R1's hospital after visit summary dated 4/1/26 indicated R1 was seen for a fall with a hematoma (localized collected of clotted or partially clotted blood outside causing swelling, pain, and skin discoloration) of the frontal scalp. R1's subsequent Transitional Rehabilitation Program note dated 4/2/26 indicated on 4/1/26 R1 was able to open a door to the stairway and fell down the first flight of stairs while still strapped to his wheelchair. He was sent for emergency evaluation. While in the Emergency Department he underwent a trauma workup and no significant injuries were found, besides a contusion on the front of his right forehead. He was set back to the facility that evening. At that time, he was placed on a 1:1 (a staff member would always be with R1). Prior to this he had remote observation. Upon interview on 4/7/26 at 2:00 p.m. the maintenance supervisor stated that the facility had not had the alarm in the stairwell in working order	F0689		05/11/2026

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F0689 SS = SQC-J	Continued from page 4 for months because the door did not need to be secure because the residents used the video surveillance system or the wander guard system (alarm placed on the resident that sounds an alarm when the resident is near a door). He was not aware of R1's fall. Upon interview on 4/7/26 at 2:31 p.m. R1's family member (FM)-A stated he was told that R1's remote observation alarm was delayed so R1 got out of his room without staff's awareness and by the time staff found him he had fallen down the stairs. When he visited staff would check on him, however not on a regular basis. (FM)-A used the unarmed door when he would visit R1 to enter and leave the facility, so he believed R1 thought that was his way out. Upon interview on 4/8/26 at 10:15 a.m. registered nurse (RN)-C stated R1's supervision was through the remote monitoring since the remote system watches residents 24 hours a day and redirects them for the staff on the unit. He would visualize R1 when he walks by his room, otherwise at shift change staff check in on all their residents. (RN)-C stated he was aware that the alarm on the door did not sound, and he did not have to use his badge to get through the door, he could not recall how long the door had been unarmed. (RN)-C did not notify anyone about the door, but management and other staff were able to walk through the door, so he did not think it was a concern. Upon interview on 4/8/26 at 10:35 a.m. the health unit coordinator (HUC) stated she was aware the door was unarmed. She did not report it to maintenance because she saw management use the door without their badge, so she assumed there were no concerns. Upon interview on 4/8/26 at 11:11 a.m. nursing assistant NA-A stated the supervision for R1 was the remote observation system because R1 was unable to use his call light to call for help. There were no criteria for checking on him and it would be unrealistic to check on him hourly because within the hour he could have fallen. She was unaware that the door was unarmed. Upon interview on 4/8/26 at 11:25 a.m. the security supervisor stated he came to the facility to check on the door. He stated the alarm had been turned off in	F0689		05/11/2026

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F0689 SS = SQC-J	Continued from page 5 March and turned back on 4/1/26. He stated he was not certain how the facility checked for the doors to be working. He could see that multiple staff continued to use their badge since the alarm was shut off. Upon interview on 4/8/26 at 12:25 p.m. the offsite remote observation supervisor stated her team did an investigation, and they found their team member did not follow the work standard. The technician who was watching R1 walked away from his desk and within a few seconds R1 had left his room. When the technician saw R1 was not in his room he called the charge nurse at the facility. The protocol should have been to have sounded the remote alarm so the facility would have heard the alarm and searched for R1 more quickly. Upon interview on 4/8/26 at 1:36 p.m. RN-D stated R1's supervision was the remote observation, the chair and bed alarms. He was wondering why he no longer needed to use his badge for the door, but thought management had made a change. Upon interview on 4/8/26 at 1:48 p.m. RN-E stated a little after 4:10 on 4/1/26 he received a call from the remote observation technician and what he thought the technician said was that R1 had left his room with a facility staff member so RN-E was not concerned. A few seconds later he heard a wander guard alarm sound. He ran to the door and found R1 had fallen down the first set of stairs in the stair well. R1 was face down with his wheelchair on top of him. He had to cut R1's lap belt off him. R1 was conscious, emergency medical services were called and R1 was taken to the hospital. RN-E stated after R1 was transferred to the hospital he was informed by NA-B that R1 had increased agitation and had attempted to leave the building the prior day. Upon interview on 4/8/26 at 3:10 p.m. NA-B stated she worked the evening R1 fell. She also responded to the wander guard alarm and found R1 face down with his wheelchair attached to him. R1 was supervised with the remote observation and his alarms, but they failed him on 4/1/26. Upon interview on 4/9/26 at 11:05 a.m. R1's Nurse Practitioner (NP) stated the facility uses multiple devices for all the residents for their safety. He stated after the fall he ordered staff to also	F0689		05/11/2026

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F0689 SS = SQC-J	Continued from page 6 supervise R1. Upon interview on 4/9/26 at 1:04 p.m. RN-B stated R1's supervision was the remote observation unit, and he should have been on hourly rounding as well. The facility was thinking of stopping the remote observation as they felt it was agitating R1 more. The wander guard alarm was started prior to the fall on 4/1/26 due to increased agitation and R1 attempting to elope out the same door the previous day. RN-B was not aware the door alarm had been turned off. Upon interview on 4/9/26 at R1's medical provider stated he was aware that R1 had gotten through the door and fell with his wheelchair attached to him. He could not be certain how having R1 belted into his chair could have changed the fall. He was not aware the emergency alarm on the door was not working and if they could have prevented the fall either. He stated the door needed to be fixed and even with all the devices staff should also be supervising the residents. Upon interview on 4/13/26 at 10:26 a.m. the Administrator stated the staff supervise the residents even with the use of the remote observation and alarms. She believed R1 was being supervised every hour by staff. Secure Care Products (wander guard) user manual with a revision date of 11/16/07 indicated Secure Care's software, parts and products have been designed to augment a facility's reasonable procedures for protecting residents, patients, and infants. However, no system or combination of procedures and equipment can eliminate all risk or assure complete security. Secure Care's system is not intended as a substitute for the careful identification and monitoring of residents, patients, and infants by a facility's professional staff. The manual indicated that weekly testing of wandering patients should be tested to make sure the transmitter is working. -Monthly testing should be performed for the fire alarm release feature. -The annual service was recommended to be sure the battery was replaced. -Onguard user guide (the employee badge alarm	F0689		05/11/2026

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F0689 SS = SQC-J	Continued from page 7 locks) dated 1/2005 indicated how to set up the alarms and how to check the arms but did not indicate how often a facility should be checking the alarms. Allegion user guide dated 2021 indicated The Von Duprin Chexit device is designed for controlled egress applications. It meets both life safety and security needs, as well as the requirements of NFPA101 for “Special Locking Arrangement” and IBC “Special Egress-Control Devices”. All control inputs, auxiliary locking, local alarm and remote signaling outputs are self-contained in the Chexit assembly. Numerous field configurable options allow the device to be customized for the specific code or application requirements. The standard Chexit device sounds an alarm and keeps the door secured for 15 seconds following an exit attempt with immediate release upon fire. The manual indicated how to test the powerup, the delayed egress and an advanced function test, however, did not indicate how often a facility should be testing the devices. Policies regarding accidents and equipment inspections were requested, however none was received. The Immediate Jeopardy (IJ) began on 4/1/26 when R1 fell down the facilities stairwell. The Administrator and the director of nursing were notified of the immediate jeopardy on 4/7/26 at 5:15 p.m. The immediate jeopardy was removed on 4/9/23 at 5:43 p.m., when the facility trained all staff about reporting when they are aware a door is unarmed. The facility made plans to make the second emergency door into an armed door to mirror the door R1 went out of. The facility placed signs on the unarmed door and used remote observation 24 hours a day to alarm if a resident or staff attempted to use the door. Staff were educated to respond immediately when they heard the remote alarm sound. The facility audited staff to ensure staff responded. but noncompliance remained at the lower scope and severity, level 2, F – widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F0689		05/11/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F0550	Courage Kenny Rehabilitation Institute - TRP treats each resident with respect and dignity and cares for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	05/11/2026

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F0550 SS = D	Continued from page 8 The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide respect and dignified treatment for 1 of 3 residents (R3) reviewed for dignity. R3 was given a bed alarm that R3 stated he did not consent to. The alarm limited his freedom of movement when he was in bed due to feeling startled by the loud sound of the alarm. In addition, he was anxious because he was concerned his alarm would bother residents near his room.	F0550	Continued from page 8 individuality. R3 has discharged from the facility. Residents with potentially restraining devices will be reassessed to ensure no devices negatively impact the residents' rights. The policy regarding Resident Rights has been reviewed and no changes were necessary. The policy regarding restraints will be reviewed and revised as needed. Staff will be re-educated regarding resident rights and potentially restraining devices, including informed consent and how alarms can impact residents psychosocially, as well as proper placement of bed alarms. Staff who have not completed the education by the completion date will complete it prior to beginning their next scheduled shift. The Administrator or designee will conduct weekly audits of residents with potentially restraining devices to ensure their rights are not negatively impacted. Audits will continue until the 5/28/26 QAPI meeting. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	05/11/2026

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F0550 SS = D	Continued from page 9 Findings include: The facilities Consent Form for Restraints dated 2/2/26 indicated R3 signed giving consent for the medication trazodone and side rails on his bed. The bed alarm was not on the consent form. R3's admission minimum data set (MDS) dated 2/9/26 indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3 had mentioned his concerns to the staff. R3's care plan dated 2/4/26 indicated R3 had a bed alarm. The care plan did not indicate how often the alarm was to be used or the placement of the alarm under his body. Upon observation and interview on 4/9/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the lap belt alarm on his wheelchair and the alarm on his wheelchair when he left the unit (wander guard), but he was bothered by the bed alarm. He stated he did not consent to having the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. Upon interview on 4/9/26 at 11:05 a.m. the Nurse Practitioner stated he was aware that R3 had complained about his bed alarm and stated the staff reassured him the alarm was there for his safety and R3 was very cognitively impaired, so staff had to remind him often about his safety needs. Upon interview on 4/9/26 at 1:04 p.m. registered nurse, (RN)-B the nurse manager stated she was not aware that R3 had complaints with his bed alarm, she stated she would fix it immediately by having staff place the alarm up higher on his back, so he can move his legs easier while in bed and the alarm	F0550		05/11/2026

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F0550 SS = D	Continued from page 10 should not sound then unless he stood up. Upon interview on 4/9/26 at 2:06 p.m. the director of nursing, (DON) stated she had not heard of R3's allegations, however when the alarm stops when a resident stops moving their legs. Upon interview on 4/9/26 at 2:33 p.m. R3's Medical Provider stated he had not heard of R3's bed alarm complaint and was not certain how the staff should proceed as safety was the main concern. He thought the staff approach could be modified. Upon interview on 4/13/26 at 9:55 a.m. the Medical Director stated if R3 was having concerns with the bed alarm the facility should try an alternative and the facility should be addressing the concerns stating there is a need to keep him safe, catch him when we think he is getting out of bed, and respect his right to move. A facility policy titled Resident rights dated 9/30/25 indicated Planning and Implementing Care – The facility will: -Permit the resident/resident representative to participate in the development, revision, and implementation of a person-centered plan of care. This includes the right to identify individuals or roles to be included in the planning process, the right to participate in establishing the expected goals and outcomes of care, the right to sign the plan of care, and the right to be informed (in advance) of changes to the plan of care. Inform the resident/resident representative of the right to participate in their treatment and provide support to the resident/resident representative in doing so. This should include information concerning the care to be furnished and the type of caregiver/professional to render services. -Ensure that the physician/practitioner or other professional has informed the resident in advance of the risks/benefits of proposed care, treatment and treatment alternatives/options and the right to choose same. Recognize the resident's right to request/refuse/discontinue treatment, to participate/refuse participation in experimental research, and to formulate an advance directive.	F0550		05/11/2026

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F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation interview and document review, the facility failed to implement a process to assess for, determine medical symptoms, obtain an order prior to use, assess for use of the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints for 3 of 3 residents (R1, R2, R3) reviewed for use of physical restraints. Findings include: Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 Section P: Restraints and Alarms	F0604	Courage Kenny Rehabilitation Institute - TRP ensures that the resident is free from physical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility uses the least restrictive alternative for the least amount of time and documents ongoing re-evaluation of the need for restraints. R1 and R3 have discharged from the facility. R2 has been reassessed to ensure no devices negatively impact the resident's rights. Residents with potentially restraining devices will be reassessed to ensure no devices negatively impact the residents' rights. The policy regarding restraints will be reviewed and revised as necessary. The PT Mobility Assessment has been revised to prompt reassessment of the appropriateness of potentially restraining devices with changes in mobility or transfer status. The Physical Device Assessment will be reviewed and revised as necessary. Physical Device Assessments will be completed at admission and quarterly. Staff will be re-educated regarding resident rights and potentially restraining devices, including informed consent and how alarms can impact residents psychosocially, as well as proper placement of bed alarms. Staff who have not completed the education by the completion date will complete it prior to beginning their next scheduled shift. The Administrator or designee will conduct weekly audits of residents with potentially restraining devices to ensure their rights are not negatively impacted. Audits will continue until the 5/28/26 QAPI meeting. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	05/11/2026

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F0604 SS = D	Continued from page 12 indicated physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident. Physical restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers. Upon observation and interview on 4/7/26 at 12:17 p.m., R1 was observed to have bilateral quarter side rails at the head of his bed and three-quarter length side rails at the foot of his bed. R1 was seated in his wheelchair with an alarmed seat belt around his waist. On the back of his chair, he had a wander guard bracelet attached to his wheelchair. R1 was not certain what the side rails on his bed were for. He stated that the bed was the bed he slept in. He could not take the lap belt off by himself. He then started speaking incoherently about working in his car in his shop. R1's Physical Device assessment dated 3/11/26, indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability to appropriately use the device. The device did not restrict voluntary freedom of moment or prevent access to any body part. He understood the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried.	F0604		05/11/2026

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F0604 SS = D	Continued from page 13 R1's admission Minimum Data Set (MDS) dated 3/18/26, indicated R1 had a brief inventory of mental status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). R1's care plan dated 3/23/26, indicated R1 may use half side rails for positioning and safety when in bed. R1. The side rails were to be used when he was in bed to allow for safe positioning due to spasms. His care plan did not indicate there were side rails attached to the foot of his bed or any interventions for those. R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. The care plan did not indicate when the staff was to release the belt to give R1 freedom of movement. R1 had a wander guard (an electronic security system that uses a bracelet on a resident that alarms when the resident tries to wander outside the facility) that was not identified on the care plan or any interventions for use. Upon observation on 4/8/26 at 8:55 a.m., R2 was in bed, she had bilateral quarter side rails at the head of her bed. She had a seat belt alarm in her wheelchair and a wander guard bracelet attached to the back of her wheelchair. When she was dressed and moved to her wheelchair, she was unable to move her right arm and was unable to remove the lap belt on her own. R2 could not speak, she would nod yes and no to questions. R2's Physical Device Assessment dated 2/27/26, indicated R2 had quarter size left and right-side rails. She was able to demonstrate the ability to use the device appropriately and they did not restrict her voluntary freedom of movement or prevent access to a body part. Her decision maker understood the risk and benefits. R2's symptoms were weakness, impaired mobility, hemiplegia, rehab, to facilitate independence. Her diagnoses of CVA and no less restrictive devices were tried.	F0604		05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

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F0604 SS = D	Continued from page 14 R2's admission MDS dated 3/6/26 indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2's BIMS score was 00 which indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent on toileting and transfers. Her pertinent diagnoses were cerebral infarction (stroke), aphasia (impairment caused by brain damage that impairs a person's ability to process language, speak, read, write, and understand speech), dysphagia (difficulty swallowing), symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2's care plan dated 2/27/26 did not indicate R2 had bilateral quarter sized side rails, the seat belt alarm, or the wander guard. Upon observation and interview on 4/8/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the alarm belt on his wheelchair and the alarm on his wheelchair when he left the unit, but he was bothered by the bed alarm. He stated he did not consent to put the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. R3's Physical Device Assessment dated 2/2/26 indicated R3 had right and left quarter sized rails on his bed. He was able to demonstrate the ability to use the device appropriately and it did not restrict any voluntary freedom of movement or prevent access to any body part. Client and decision maker did not say they understood the risk and benefits. R3's symptoms were impaired judgement and hemiplegia. R3's diagnosis was a CVA, and no less restrictive devices were tried. R3's summary indicated quarter side rails on bed to help with turning and reposition. R3's admission MDS dated 2/9/26, indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for	F0604		05/11/2026

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F0604 SS = D	Continued from page 15 toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's care plan dated 2/4/26 indicated R3 had a bed alarm, seat belt alarm to be on when in his wheelchair to aide in trunk support, grab bars/bedrails. Email correspondence following the survey on 4/15/26 from the Administrator revealed a facility in-house email chain indicated RN-F interviewed R1, R2 and R3 on 4/10/26 at 3:53 p.m. see below: R3- says he likes and uses the bedrail, able to take off his seatbelt, thinks the seat belt is a good idea, doesn't like the bed or seatbelt alarms because there are too many false alarms, he would be ok with them if they only alarmed when he actually needed them to, but they alarm when he just raises his leg. R1 - says he likes and uses the bedrails, was unable to take off his seatbelt for me, even with prompting, says he hates the seatbelt and the seatbelt alarm and bed alarm. R2 - nodded yes that she likes and uses the bed rails, was able to take off her seatbelt when I asked her to show me, nodded yes that she likes the seat belt, and the bed and the seatbelt alarms. Email correspondence dated 4/11/26 from the Administrator to PT-A indicated R1, R2 and R3 all used the bedrails for either repositioning or transferring. The facility was going to find R1 a different type of belt that R1 could remove. R1 was still on a 1:1 (one staff with a resident all the time) therefore an alarm was not necessary. Email correspondence dated 4/12/26 email from PT-A to the administrator indicated she attempted to see R1 twice on Saturday 4/11/26 the first attempt he was too agitated and second attempt R1 had visitors. She would follow up to make sure this happens on Monday (4/13/26). She recommended 1:1 staff needed to are aware the change will happen. She indicated she was concerned if R1 could easily be able to get his seat belt off, he	F0604		05/11/2026

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F0604 SS = D	Continued from page 16 would stand up even with someone in the room and likely fall. She indicated she understood this is part of the state recommendation however she wanted to make sure they had a plan to keep him and staff safe. Upon interview on 4/8/26 at 11:11 a.m., nursing assistant (NA)-A stated she had never been told to release any of the residents on the unit who wore lap belts. R1 could remove his belt, because he often did it and staff would have to response, but he did not understand what the belt was for. R2 had never attempted to stand up or remove her alarm when NA-A had worked with her. R3 had complained about his bed alarm and was told by staff it was for his safety. Upon interview on 4/8/26 at 11:59 a.m. physical therapist (PT)-A stated it was the facilities standard of practice for anyone with a brain injury to get a lap belt and side rails placed upon admission. The reason for the restraints was because the residents could try to self-transfer and fall. Some residents need the lap belt because they are unable to understand how to call the nurse for help, if they release the belt the alarm would sound, and staff would assist. R1 could remove his belt, but he cannot remember things from day to day, was the reason he required the lap belt. The facility did not have it care planned that staff were to remove the seat belt as R1 could only walk with therapy assistance. R1 could follow only one step commands, he would become tired and then agitated so he could fall. Residents have side rails for turning and repositions and our beds are narrow, so the residents needed the rails to keep them safe from falling out of bed. Upon interview on 4/8/29 at 1:48 p.m. registered nurse (RN)-E stated all residents have the lap belts and side rails upon admission until they are assessed by therapy services. Nursing had nothing to do with any equipment assessments, Occupational and Physical Therapy completed equipment assessments. Upon interview 4/8/26 at 2:29 p.m. PT-B stated upon admission the residents did receive the lap belt and the side rails. The brain injury diagnosis the restraints were used was usually for forgetfulness and impulsiveness and the spinal cord injury residents diagnoses for the restraints for trunk	F0604		05/11/2026

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F0604 SS = D	Continued from page 17 support. Therapy assessed the residents usually within the first day of admission and would then assess the appropriateness of the lap belt and side rails. R1 was recommended to have the 24-hour remote observation, the seat lap belt, the bed alarm, and the side rails. R1 did not have the cognition to make himself safe so therapy implemented the safety devices. If R1 were to stand-up he would fall. The alarms were treating R1's impulsiveness. The seat belt alarm, the side rails, and the bed alarms were the least restrictive devices. Laps belts were not considered a restraint if the resident can remove it by themselves or ask someone else to remove it for them. The facility had different levels of belts, some disengaged easier than others. All facilities departments meet for daily interdepartmental meetings and discuss the needs of the residents. (PT)-B believed R2 could remove her lap belt, she stated if she cannot even though she is unable to speak, she could use her call light and could call for a nurse to assist her. R3 required the seat belt, side rails, and bed alarm due to falls. "We need to have as many noises as possible, so we can get to the residents as soon as possible." Upon interview on 4/8/26 at 3:10 p.m. NA-A stated R1 took off his bed multiple times a shift. He did not understand what the belt was for, he would fidget with the belt when he was agitated. The staff only removed the lap belts for R1, R2, and R3 when they needed to use the bathroom or went to bed. Upon interview on 4/9/26 at 11:05 a.m. the nurse practitioner (NP) stated the lap belts; the side rails and the bed alarms were safety for the residents. Without the devices residents would fall. He was not certain what assessments therapy performed for the residents. He was not certain if any less restrictive devices had been attempted or what ongoing monitoring looked like. He did not order any of the devices. He signed whatever therapy assessed. He stated the medical diagnoses for R1, R2 and R3 would be cognitive concerns and impulsiveness. The residents did not have good judgement, which was the reason they had the devices, so they did not fall. Upon interview on 4/9/26 at 1:04 p.m. RN-B stated the standard process for admitting residents with a brain injury was to get a bed alarm, lap belt, and side rails. Therapy completed all the device assessments, no nursing. She did not have an admission protocol document to offer.	F0604		05/11/2026

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F0604 SS = D	Continued from page 18 Upon interview on 4/9/26 at 2:06 p.m. the director of nursing stated the benefits outweighed the risk with the lap belt, the side rails, and the alarm. A request was made during the interview for the DON to provide the following documentation for R1, R2 and R3 regarding the restraint use: Medical diagnosis, conditions, symptoms, and/or behavioral symptoms. Size and weight. Sleep habits. Medication(s). Acute medical or surgical interventions. Underlying medical conditions. Existence of delirium. Ability to toilet safely. Cognition. Communication Mobility (in and out of bed) Risk of falling. evaluation of the alternatives that were attempted prior use Inspections of the devices. No documentation was received for the requested documentation. Upon interview on 4/13/26 at 9:55 a.m. the Medical Director stated the facility was very aware of the restraint regulations. She stated the lap belts were used for trunk control. The department teams meet daily to discuss removal of any alarms when the resident is ready. She was not aware that residents received the lap belt, bed alarm, and side rails on admission automatically. The facility was weighing the risks versus the benefits, and the facility tried to minimize the risk of falls. Alarms in residents with dementia can worsen the dementia, but the residents at the facility did not service a dementia population. The facility used the side rails as a tool for the residents to be more independent in their beds. R1	F0604		05/11/2026

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F0604 SS = D	Continued from page 19 can remove his belt, not on command due to his delirium. Her expectation was the staff were following the guidelines of the facility assessments. The care plans were made for the staff to always ensure resident safety. She was not familiar with R2 or R3. She stated if R3 felt restricted with his bed alarm the facility should have tried an alternative to not restrain him. Upon interview on 4/13/26 at 10:26 a.m. the Administrator stated having the devices of the lap belt, the bed alarm, and the side rails were the standard of practice used by the facility and for safety of the residents. "It is the best practice". The facility admission policy titled Admission and Continued Stay Criteria dated 8/30/26 indicating. The Transitional Rehabilitation Program (TRP) provides holistic, comprehensive, inpatient neurological rehabilitation services to assist adults with disabilities and/or recovering from illness, injury, or surgery in gaining greater independence. The TRP is licensed as a skilled nursing facility and serves as a “bridge” or transitional setting between acute care and returning to a community living setting. During the program, people are required to actively participate in therapies/programming to accomplish their goals. Admissions staff complete a preadmission assessment to determine whether the potential client requires the specialized programming offered by the TRP and whether the TRP can meet the potential client’s needs. Care Specialties: Cerebrovascular Disorders (e.g., stroke, aneurysm) Spinal Cord Injury Brain Injury Neurovascular Disorder (e.g., spinal stroke) Other Complex Neurological/Neuromuscular disorders (e.g., Guillain-Barre Syndrome) The policy did not indicate any information on restraints being used. A facility policy titled Restraints dated 1/23/24 indicated that Transitional Rehabilitation Program (TRP) supports the right of residents to be free from any physical or chemical restraint. Restraints have the potential to produce serious consequences, such as physical or psychological harm, and loss of	F0604		05/11/2026

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F0604 SS = D	Continued from page 20 dignity. Restraints will only be utilized as outlined in the State and Federal Nursing Home Resident's Bill of Rights (see addendum 1). POSITIONING AND SAFETY DEVICES Safety devices are used to enable the residents to attain or maintain their highest level of independent functioning and safety. The decision to use these aids and positioning devices is made through resident participation in individual assessment and care planning by the interdisciplinary team. They are used only with resident consent and under physician order and direction. The interdisciplinary team conducts an individual assessment/evaluation to determine the need for any positioning/potentially restraining/safety device. A care plan is developed to identify the residents' needs and parameters for use of the device, i.e., bed rails up at night so residents may use it to assist with turning. This care plan is reviewed at least quarterly and updated as needed. Prior to implementing the care plan, the nurse will review the risks and benefits of the use of the device with the resident. The resident, or if unable, the resident representative, signs the informed consent form and it is placed in the health record. Anytime a resident is using a positioning device, staff will assess the client's safety and comfort and will release the restraint as often as the resident requires for comfort, toileting, or other activities of daily living. Per the Nursing Home Residents' Bill of Rights, if a competent nursing home resident or their legal representative requests a restraint, staff will provide education regarding alternatives and the risks involved with restraint use. The facility will provide a physical restraint to a resident only upon receipt of informed consent and a written order from the attending physician that contains statements and determinations regarding medical symptoms and specifies the circumstances under which restraints are to be used. The restraint will be monitored and there will be documentation that procedures have been followed. Periodic reevaluation of the need for restraints will be conducted in consultation with the residents, family, and physicians. A physical restraint is any manual method, physical or mechanical device,	F0604		05/11/2026

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F0604 SS = D	Continued from page 21 equipment, or material that meets all the following criteria: • Is attached or adjacent to the resident's body. • Cannot be removed easily by the resident; and • Restricts the resident's freedom of movement or normal access to their body. Devices used in the facility may potentially be considered restraining include, but are not limited to, wheelchair and commode belts, lap trays, positioning devices, and bedside rails.	F0604		05/11/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to develop a person-centered care	F0657	Courage Kenny Rehabilitation Institute - TRP develops a comprehensive person-centered care plan for each resident. R1 and R3 have discharged from the facility. R2 has been reassessed to ensure no devices negatively impact the resident's rights and the care plan will be reviewed and revised as necessary. Residents with potentially restraining devices will be reassessed to ensure no devices negatively impact the residents' rights and the care plan will be reviewed and revised as necessary. The policy regarding person-centered care planning will be reviewed and revised as necessary. The PT Mobility Assessment has been revised to prompt reassessment of the appropriateness of potentially restraining devices with changes in mobility or transfer status. The Physical Device Assessment will be reviewed and revised as necessary. Physical Device Assessments will be completed at admission and quarterly. Staff will be re-educated regarding the need to reassess the appropriateness of potentially restraining devices at least quarterly and with changes in mobility or transfer status, the need to update the care plan as changes occur, and what the care plan must include when restraints are used. Staff who have not completed the education by the completion date will complete it prior to beginning their next scheduled shift. The Administrator or designee will conduct weekly audits of residents with a quarterly reassessment or change in mobility or transfer status to ensure the appropriateness of potentially restraining devices	05/11/2026

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F0657 SS = D	Continued from page 22 plan that included all the medical devices in use and develop interventions for the safe use of the devices for 3 of 3 residents (R1, R2, and R3) who were reviewed for care plan development. Findings include: Upon observation and interview on 4/7/26 at 12:17 p.m. R1 was observed to have bilateral quarter side rails at the head of his bed and three-quarter length side rails at the foot of his bed. R1 was seated in his wheelchair with an alarmed seat belt around his waist on the back of his chair he had a wander guard bracelet attached to his wheelchair. R1's admission Minimum Data Set (MDS) dated 3/18/26 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). R1's care plan dated 3/23/26 indicated R1 may use half side rails for positioning and safety when in bed. R1. The side rails were to be sued when he was in bed to allow for safe positioning due to spasms. His care plan did not indicate the side rails attached to the foot of his bed or any interventions for them. R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. The care plan did not indicate when the staff was to release the belt to give R1 freedom of movement. R1 had a wander guard (an electronic security system that uses a bracelet on a resident that alarms when the resident tries to wander outside the facility) that was not identified on the care plan or any intervention. Upon observation on 4/9/26 at 8:55 a.m. R2 was in bed, she had bilateral quarter side rails at the head of her bed, she had a seat belt alarm in her wheelchair and a wander guard bracelet attached to her wheelchair.	F0657	Continued from page 22 was reassessed, that the care plans reflect current use of potentially restraining devices, and if restraints are used the care plan includes all required elements. Audits will continue until the 5/28/26 QAPI meeting. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	05/11/2026

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F0657 SS = D	Continued from page 23 R2's admission MDS dated 3/6/26 indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2's BIMS score was 00 indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent in toileting and transfers. Her pertinent diagnoses were cerebral infarction, aphasia, dysphagia, symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2's care plan dated 2/27/26 did not indicate R2 had bilateral quarter sized side rails, the seat belt alarm, or the wander guard. Upon observation and interview on 4/8/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the alarm belt on his wheelchair and the alarm on his wheelchair when he left the unit, but he was bothered by the bed alarm. He stated he did not consent to put the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. R3's admission MDS dated 2/9/26 indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction (stroke), dysphagia (difficulty swallowing) aphasia (impairment of a person's ability to process language, speak, read, write, and understand speech), abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's care plan dated 2/4/26 indicated R3 had a bed alarm, seat belt alarm to be on when in his wheelchair to aide in trunk support, grab bars/bedrails. Upon interview on 4/9/26 at 9:12 a.m. nursing	F0657		05/11/2026

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F0657 SS = D	Continued from page 24 assistant (NA)-A stated even though R2's devices were not on her care plan she knew what to do because most of the residents have the same equipment and she has been trained and used all of the equipment before. She stated the side rails are used for positioning, the belt is to always be on when residents are in their wheelchairs, and the wander guard was so residents could not leave the unit. Upon interview on 4/9/26 at 2:06 p.m. the director of nursing (DON) stated if all the devices are not on the care plan they should be. Upon interview on 4/13/26 at 3:22 p.m. the Administrator stated her expectation that all cares, services, and interventions were on each resident's care plan. A facility policy titled Person-Centered Care Planning dated 1/3/25 indicated: A comprehensive person-centered plan of care will be developed for each client within 7 days after completion of the comprehensive assessment and will include measurable objectives and times to meet a client's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive plan of care will minimally include: • The services that are to be furnished to attain or maintain the client's highest practicable physical, mental, and psychosocial well-being. • Any services recommended by the interdisciplinary team but refused by the client. • The client's goals for admission and desired outcomes. • The client's preference and potential for future discharge. • Discharge plans 1. The comprehensive care plan will be prepared by an interdisciplinary team that includes, but is not limited to: a. The attending provider b. An RN with responsibility for the client	F0657		05/11/2026

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F0657 SS = D	Continued from page 25 c. A resident assistant with responsibility for the client d. A member of food and nutrition services staff e. If practical the client and the client's representative. If not practical, document an explanation why the client or client representative are not part of the development of the plan of care. f. Other appropriate staff or professionals in disciplines as determined by the client's needs or as requested by the client. 2. Review and revise the comprehensive plan of care after each assessment and include both the comprehensive and quarterly review assessments.	F0657		05/11/2026
F0909 SS = D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as a part of the regular maintenance program to identify areas of possible entrapment for 3 of 3 residents (R1, R2, and R3) reviewed for side rails. The facility did not provide any documentation of inspection or entrapment assessments. Findings include: Recommendations for Health Care Providers Using Adult portable Bed Rails dated 2/27/2023 retrieved on 4/13/26 from https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/hospital-beds indicated, when evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care https: Evaluating the dimensional limits of gaps in hospital	F0909	Courage Kenny Rehabilitation Institute - TRP conducts regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. R1 and R3 have discharged from the facility. The bed for R2 has been assessed to ensure no areas of possible entrapment. The beds of residents with bed rails will be reassessed to ensure no areas of possible entrapment. An evidence-based Bed Rail Entrapment Zone Measurement Tool has been acquired by the facility. Staff responsible for completing Bed Rail Entrapment Zone Measurements have completed education on properly conducting the assessment. A Bed Rail Entrapment Zone Measurement policy and procedure will be developed. Bed Rail Entrapment Zone Measurement will be completed at admission and when changes are made to the bed. Annual inspection of beds per manufacturer's recommendations has been added to the preventive maintenance plan. Staff will be educated regarding the need to request a Bed Rail Entrapment Zone Measurement when changes are made to a resident's bed (e.g., introduction of a different mattress). Staff who have not completed the education by the completion date	05/11/2026

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F0909 SS = D	Continued from page 26 beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. Bed safety programs may also include plans for the reassessment of hospital bed systems. Reassessment may be appropriate when (1) there is reason to believe that some components are worn (e.g., rails wobble, rails have been damaged, mattresses are softer) and could cause increased spaces within the bed system, (2) when accessories such as mattress overlays or positioning poles are added or removed, or (3) when components of the bed system are changed or replaced (e.g., new bed rails or mattresses). This guidance describes seven zones in the hospital bed system where there is potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. Descriptions of the seven entrapment zones appear on pages 15-21 in this guidance. Summary drawings of entrapment for all the zones appear in Appendix E. The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below. Zone 1: Within the Rail Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support Zone 3: Between the Rail and the Mattress Zone 4: Under the Rail, at the Ends of the Rail Zone 5: Between Split Bed Rails Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board Zone 7: Between the Head or Foot Board and the Mattress End. Health Care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight,	F0909	Continued from page 26 will complete it prior to beginning their next scheduled shift. The Administrator or designee will conduct weekly audits of new admissions to ensure Bed Rail Entrapment Zone Measurement was completed. Audits will continue until the 5/28/26 QAPI meeting. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	05/11/2026

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F0909 SS = D	Continued from page 27 movement, bed position, or by using a specialty mattress. The manufacture user-service manual for Baxter Hill-Rom Centrella Medical-Surgical Hospital Bed, undated, indicated Warning-Evaluate patients for entrapment and fall risk according to facility protocol, and/or healthcare provider directives, and monitor patients appropriately. Make sure all side rails are fully latched when in the raised position. Failure to do either of these could cause serious injury or death. Do annual preventive maintenance procedures to make sure the Centrella Smart+ Bed operates as originally designed. The procedures include examinations of these: Overall condition Siderails Controls and motors Battery Backup Brakes and casters Seale system Head angle display Communication system Transport system Transport system batteries Mattress Accessories WARNING: To help prevent serious injury and/or death, obey these warnings: Warning-Evaluate patients for entrapment and fall risk according to facility protocol and monitor patients appropriately. Warning-Make sure that all side rails are fully latched when in the raised position. Warning-Stay clear of pinch points and moving parts during siderail operation. Siderails are intended to be a reminder to the patient of the bed's edges, not a patient-restraining device. When appropriate, Hill-Rom recommends that medical persons determine the correct methods necessary to make sure a patient stays safely in bed. Siderails in the raised position are intended to make	F0909		05/11/2026

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F0909 SS = D	Continued from page 28 the patient aware of the proximity of the edge of the mattress and to assist in patient entry and exit. R1's Physical Device assessment dated 3/11/26 indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability appropriately using the device as applicable. The device did not restrict voluntary freedom of moment or prevent access to any part. His decision made him understand the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried. Upon observation and interview on 4/7/26 at 12:17 p.m. R1 was seated in his room in wheelchair. He had bilateral quarter rails at the top of his bed that were in the upright position. He had bilateral three-quarter length side rails at the bottom of bed that were lowered. R1 stated, he did not know what the side rails were, but they were on the bed he slept in. He then started speaking nonsensical about having to leave for work and repair cars. R1's Physical Device assessment dated 3/11/26 indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability appropriately use the device as applicable. The device did not restrict voluntary freedom of moment or prevent access to any part. His decision made him understand the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried. R1's physical therapy assessments and notes dated 3/11/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R1's occupational therapy assessments and notes dated 3/11/26 – 4/6/26 did not indicate side rails were in use for R1 or any entrapment assessment.	F0909		05/11/2026

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F0909 SS = D	Continued from page 29 R1's admission Minimum Data Set (MDS) dated 3/18/26 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). MDS did not include use of bedside rails. R1's care plan dated 3/23/26 indicated R1 may use half side rails for positioning and safety when in bed. No other documentation related to the use of side rails was indicated. Upon observation and interview on 4/9/26 at 8:55 a.m. R2 was in bed, two nursing assistants were changing her incontinent brief and getting her dressed for the day. R2 had bilateral quarter sized side rails at the head of her bed. She was unable to roll herself in bed, staff assisted her to roll on her right side, and she held on to the side rail with her left hand throughout the cares. R2 was unable to move the right side of her body. R2 was only able to interview by nodding "yes or no" to questions. R2 indicated through nodding that she could not use her right hand, that she could not turn herself in bed and that she used the side rails when staff assisted her. She could not remove the side rails by herself. R2's Physical Device Assessment dated 2/27/26 indicated R2 had quarter size left and right-side rails. She was able to demonstrate the ability to use the device appropriately and they did not restrict her voluntary freedom of movement or prevent access to a body part. Her decision understood the risk and benefits. R1's symptoms were weakness, impaired mobility, hemiplegia, rehab, to facilitate independence. Her diagnoses of CVA and no less restrictive devices were tried. There was no documentation for any entrapment assessments. R2's physical therapy assessments and notes dated 2/27/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment.	F0909		05/11/2026

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F0909 SS = D	Continued from page 30 R2's occupational therapy assessments and notes dated 2/27/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R2's care plan dated 2/27/26 did not indicate the use of side rails. R2's admission MDS dated 3/6/26 indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2's BIMS score was 00 indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent in toileting and transfers. Her pertinent diagnoses were cerebral infarction, aphasia, dysphagia, symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2's MDS did not indicate the use of the side rails. Upon observation and interview on 4/9/26 at 10:25 a.m. R3 was resting on his bed fully dressed. He had bilateral half rails at the head of his bed. He stated he could reposition himself in bed and use the rails. R3's Physical Device Assessment dated 2/2/26 indicated R2 had right and left quarter sized rails on his bed. He was able to demonstrate the ability to use the device appropriately and it did not restrict any voluntary freedom of movement or prevent access to any body part. Client and our decision maker did not say they understood the risk and benefits. R3's symptoms were impaired judgement and hemiplegia. No other alternatives were tried. R3's diagnosis was a CVA, and no less restrictive devices were tried. R3's summary indicated quarter side rails on bed to help with turning and reposition. There was no documentation for any entrapment assessments. R3's physical therapy assessments and notes dated 2/2/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R3's occupational therapy assessments and notes dated 2/2/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment.	F0909		05/11/2026

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F0909 SS = D	Continued from page 31 R3's care plan dated 2/9/26 did not indicate the use of side rails. R3's admission MDS dated 2/9/26 indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's MDS did not indicate the use of side rails. On 4/9/26 at 10:45 a.m. a request was made to the maintenance engineer for any documentation of assessments or inspections of resident side rails. No documentation was received. On 4/9/26 at 11:22 a.m. a request was made to the administrator for any documentation of assessments or inspections of resident side rails. She stated she would send the information. No information was received. Upon interview on 4/7/26 at 12:41 p.m. registered nurse (RN)-A stated she was unaware of any safety precautions or inspections on the side rails. She stated therapy was in charge of all equipment. She was not certain if R1 used the lower side rails or if they just were not removed from his bed upon his admission. Upon interview on 4/7/26 at 1:48 p.m. the maintenance engineer stated he had not done anything with side rails expecting to fix them when nursing reports they are broken. Upon interview on 4/8/26 at 11:59 a.m. Physical Therapist (PT)-A stated residents who have a brain injury are all admitted with side rails and a lap belt and then when they saw therapy for the first time devices could be adjusted. She stated nursing would complete any assessments for safety such as the zoning in the bed.	F0909		05/11/2026

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F0909 SS = D	Continued from page 32 A facility policy titled Restraints dated 1/23/24 indicated safety devices are used to enable the residents to attain or maintain their highest level of independent functioning and safety. The decision to use these aids and positioning devices is made through resident participation in individual assessment and care planning by the interdisciplinary team. They are used only with resident consent and under physician order and direction. PROCEDURE: 1) The interdisciplinary team conducts an individual assessment/evaluation to determine the need for any positioning/potentially restraining/safety device. A care plan is developed to identify the residents' needs and parameters for use of the device, i.e., bed rails up at night so residents may use it to assist with turning. This care plan is reviewed at least quarterly and updated as needed. 2) Prior to implementing the care plan, the nurse will review the risks and benefits of the use of the device with the residents. The resident, or if unable, the resident representative, signs the informed consent. The policy did not indicate any inspection timing of the devices.	F0909		05/11/2026
F0846 SS = C	Facility Closure CFR(s): 483.70(l) §483.70(l) Facility closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (l) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a facility closure policy and procedure had been developed. This had the potential to affect all residents residing in the building. Findings include: A policy and procedure covering facility closure was requested from the facility, but facility failed to provide such documentation.	F0846	No residents were affected by not having a policy for facility closure. All residents could potentially be affected if the facility closed. A Facility Closure policy will be developed. Staff will be educated regarding the Facility Closure policy. Staff who have not completed the education by the completion date will complete it prior to beginning their next scheduled shift. The Administrator or designee will conduct weekly audits to ensure no violations of the Facility Closure policy have occurred. Audits will continue until the 5/28/26 QAPI meeting. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	05/11/2026

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F0846 SS = C	Continued from page 33 Email correspondence dated 4/7/26 at 8:16 p.m. the Administrator indicated the facility did not have a policy/procedure on facility closure, as the facility had no intent to close.	F0846		05/11/2026

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20000	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: On 4/7/26 – 4/13/26 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H55191093C (MN3972520) with a licensing orders issued at (ST20520, ST21840)	20000		05/11/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/13/2026**

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20000	Continued from page 1 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 surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	20000		05/11/2026
20520	Use of Restraints CFR(s): MN Rule 4658.0300 Subp. 3 B Subp. 3. Emergency use of restraint. B. If a restraint is needed, a physician's order must be obtained which specifies the duration and circumstances under which the restraint is to be used. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation interview and document review, the facility failed to implement a process to assess for, determine medical symptoms, obtain an order prior to use, assess for use of the least restrictive alternative for the least amount of time	20520	Courage Kenny Rehabilitation Institute - TRP ensures that the resident is free from physical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility uses the least restrictive alternative for the least amount of time and documents ongoing re-evaluation of the need for restraints. R1 and R3 have discharged from the facility. R2 has been reassessed to ensure no devices negatively impact the resident's rights. Residents with potentially restraining devices will be reassessed to ensure no devices negatively impact the residents' rights. The policy regarding restraints will be reviewed and revised as necessary.	05/11/2026

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20520	Continued from page 2 and document ongoing re-evaluation of the need for restraints for 3 of 3 residents (R1, R2, R3) reviewed for use of physical restraints Findings include: Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 Section P: Restraints and Alarms indicated physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident’s body that the individual cannot remove easily, which restricts freedom of movement or normal access to one’s body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident. Physical restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers. Upon observation and interview on 4/7/26 at 12:17 p.m., R1 was observed to have bilateral quarter side rails at the head of his bed and three-quarter length side rails at the foot of his bed. R1 was seated in his wheelchair with an alarmed seat belt around his waist. On the back of his chair, he had a wander guard bracelet attached to his wheelchair. R1 was not certain what the side rails on his bed were for. He stated that the bed was the bed he slept in. He could not take the lap belt off by himself. He then started speaking incoherently about working in his car in his shop. R1’s Physical Device assessment dated 3/11/26, indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability to appropriately use	20520	Continued from page 2 The PT Mobility Assessment has been revised to prompt reassessment of the appropriateness of potentially restraining devices with changes in mobility or transfer status. The Physical Device Assessment will be reviewed and revised as necessary. Physical Device Assessments will be completed at admission and quarterly. Staff will be re-educated regarding resident rights and potentially restraining devices, including informed consent and how alarms can impact residents psychosocially, as well as proper placement of bed alarms. Staff who have not completed the education by the completion date will complete it prior to beginning their next scheduled shift. The Administrator or designee will conduct weekly audits of residents with potentially restraining devices to ensure their rights are not negatively impacted. Audits will continue until the 5/28/26 QAPI meeting. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	05/11/2026

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20520	Continued from page 3 the device. The device did not restrict voluntary freedom of moment or prevent access to any body part. He understood the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried. R1's admission Minimum Data Set (MDS) dated 3/18/26, indicated R1 had a brief inventory of mental status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). R1's care plan dated 3/23/26, indicated R1 may use half side rails for positioning and safety when in bed. R1. The side rails were to be used when he was in bed to allow for safe positioning due to spasms. His care plan did not indicate there were side rails attached to the foot of his bed or any interventions for those. R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. The care plan did not indicate when the staff was to release the belt to give R1 freedom of movement. R1 had a wander guard (an electronic security system that uses a bracelet on a resident that alarms when the resident tries to wander outside the facility) that was not identified on the care plan or any interventions for use. Upon observation on 4/8/26 at 8:55 a.m., R2 was in bed, she had bilateral quarter side rails at the head of her bed. She had a seat belt alarm in her wheelchair and a wander guard bracelet attached to the back of her wheelchair. When she was dressed and moved to her wheelchair, she was unable to move her right arm and was unable to remove the lap belt on her own. R2 could not speak, she would nod yes and no to questions.	20520		05/11/2026

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20520	Continued from page 4 R2‘s Physical Device Assessment dated 2/27/26, indicated R2 had quarter size left and right-side rails. She was able to demonstrate the ability to use the device appropriately and they did not restrict her voluntary freedom of movement or prevent access to a body part. Her decision maker understood the risk and benefits. R2’s symptoms were weakness, impaired mobility, hemiplegia, rehab, to facilitate independence. Her diagnoses of CVA and no less restrictive devices were tried. R2’s admission MDS dated 3/6/26 indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2’s BIMS score was 00 which indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent on toileting and transfers. Her pertinent diagnoses were cerebral infarction (stroke), aphasia (impairment caused by brain damage that impairs a person’s ability to process language, speak, read, write, and understand speech), dysphagia (difficulty swallowing), symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2’s care plan dated 2/27/26 did not indicate R2 had bilateral quarter sized side rails, the seat belt alarm, or the wander guard. Upon observation and interview on 4/8/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the alarm belt on his wheelchair and the alarm on his wheelchair when he left the unit, but he was bothered by the bed alarm. He stated he did not consent to put the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. R3’s Physical Device Assessment dated 2/2/26 indicated R3 had right and left quarter sized rails on his bed. He was able to demonstrate the ability to use the device appropriately and it did not restrict any voluntary freedom of movement or prevent access to any body part. Client and decision maker did not say they understood the risk and benefits.	20520		05/11/2026

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20520	Continued from page 5 R3's symptoms were impaired judgement and hemiplegia. R3's diagnosis was a CVA, and no less restrictive devices were tried. R3's summary indicated quarter side rails on bed to help with turning and reposition. R3's admission MDS dated 2/9/26, indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's care plan dated 2/4/26 indicated R3 had a bed alarm, seat belt alarm to be on when in his wheelchair to aide in trunk support, grab bars/bedrails. Email correspondence following the survey on 4/15/26 from the Administrator revealed a facility in-house email chain indicated RN-F interviewed R1, R2 and R3 on 4/10/26 at 3:53 p.m. see below: R3- says he likes and uses the bedrail, able to take off his seatbelt, thinks the seat belt is a good idea, doesn't like the bed or seatbelt alarms because there are too many false alarms, he would be ok with them if they only alarmed when he actually needed them to, but they alarm when he just raises his leg. R1 - says he likes and uses the bedrails, was unable to take off his seatbelt for me, even with prompting, says he hates the seatbelt and the seatbelt alarm and bed alarm. R2 - nodded yes that she likes and uses the bed rails, was able to take off her seatbelt when I asked her to show me, nodded yes that she likes the seat belt, and the bed and the seatbelt alarms. Email correspondence dated 4/11/26 from the Administrator to PT-A indicated R1, R2 and R3 all used the bedrails for either repositioning or transferring. The facility was going to find R1 a different type of belt that R1 could remove. R1 was still on a 1:1 (one staff with a resident all the time) therefore an alarm was not necessary.	20520		05/11/2026

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20520	Continued from page 6 Email correspondence dated 4/12/26 email from PT-A to the administrator indicated she attempted to see R1 twice on Saturday 4/11/26 the first attempt he was too agitated and second attempt R1 had visitors. She would follow up to make sure this happens on Monday (4/13/26). She recommended 1:1 staff needed to are aware the change will happen. She indicated she was concerned if R1 could easily be able to get his seat belt off, he would stand up even with someone in the room and likely fall. She indicated she understood this is part of the state recommendation however she wanted to make sure they had a plan to keep him and staff safe. Upon interview on 4/8/26 at 11:11 a.m., nursing assistant (NA)-A stated she had never been told to release any of the residents on the unit who wore lap belts. R1 could remove his belt, because he often did it and staff would have to response, but he did not understand what the belt was for. R2 had never attempted to stand up or remove her alarm when NA-A had worked with her. R3 had complained about his bed alarm and was told by staff it was for his safety. Upon interview on 4/8/26 at 11:59 a.m. physical therapist (PT)-A stated it was the facilities standard of practice for anyone with a brain injury to get a lap belt and side rails placed upon admission. The reason for the restraints was because the residents could try to self-transfer and fall. Some residents need the lap belt because they are unable to understand how to call the nurse for help, if they release the belt the alarm would sound, and staff would assist. R1 could remove his belt, but he cannot remember things from day to day, was the reason he required the lap belt. The facility did not have it care planned that staff were to remove the seat belt as R1 could only walk with therapy assistance. R1 could follow only one step commands, he would become tired and then agitated so he could fall. Residents have side rails for turning and repositions and our beds are narrow, so the residents needed the rails to keep them safe from falling out of bed. Upon interview on 4/8/29 at 1:48 p.m. registered nurse (RN)-E stated all residents have the lap belts and side rails upon admission until they are assessed by therapy services. Nursing had nothing	20520		05/11/2026

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20520	Continued from page 7 to do with any equipment assessments, Occupational and Physical Therapy completed equipment assessments. Upon interview 4/8/26 at 2:29 p.m. PT-B stated upon admission the residents did receive the lap belt and the side rails. The brain injury diagnosis the restraints were used was usually for forgetfulness and impulsiveness and the spinal cord injury residents diagnoses for the restraints for trunk support. Therapy assessed the residents usually within the first day of admission and would then assess the appropriateness of the lap belt and side rails. R1 was recommended to have the 24-hour remote observation, the seat lap belt, the bed alarm, and the side rails. R1 did not have the cognition to make himself safe so therapy implemented the safety devices. If R1 were to stand-up he would fall. The alarms were treating R1's impulsiveness. The seat belt alarm, the side rails, and the bed alarms were the least restrictive devices. Laps belts were not considered a restraint if the resident can remove it by themselves or ask someone else to remove it for them. The facility had different levels of belts, some disengaged easier than others. All facilities departments meet for daily interdepartmental meetings and discuss the needs of the residents. (PT)-B believed R2 could remove her lap belt, she stated if she cannot even though she is unable to speak, she could use her call light and could call for a nurse to assist her. R3 required the seat belt, side rails, and bed alarm due to falls. "We need to have as many noises as possible, so we can get to the residents as soon as possible." Upon interview on 4/8/26 at 3:10 p.m. NA-A stated R1 took off his bed multiple times a shift. He did not understand what the belt was for, he would fidget with the belt when he was agitated. The staff only removed the lap belts for R1, R2, and R3 when they needed to use the bathroom or went to bed. Upon interview on 4/9/26 at 11:05 a.m. the nurse practitioner (NP) stated the lap belts; the side rails and the bed alarms were safety for the residents. Without the devices residents would fall. He was not certain what assessments therapy performed for the residents. He was not certain if any less restrictive devices had been attempted or what ongoing monitoring looked like. He did not order any of the devices. He signed whatever therapy assessed. He stated the medical diagnoses for R1, R2 and R3 would be cognitive concerns and impulsiveness. The	20520		05/11/2026

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20520	Continued from page 8 residents did not have good judgement, which was the reason they had the devices, so they did not fall. Upon interview on 4/9/26 at 1:04 p.m. RN-B stated the standard process for admitting residents with a brain injury was to get a bed alarm, lap belt, and side rails. Therapy completed all the device assessments, no nursing. She did not have an admission protocol document to offer. Upon interview on 4/9/26 at 2:06 p.m. the director of nursing stated the benefits outweighed the risk with the lap belt, the side rails, and the alarm. A request was made during the interview for the DON to provide the following documentation for R1, R2 and R3 regarding the restraint use: Medical diagnosis, conditions, symptoms, and/or behavioral symptoms. Size and weight. Sleep habits. Medication(s). Acute medical or surgical interventions. Underlying medical conditions. Existence of delirium. Ability to toilet safely. Cognition. Communication Mobility (in and out of bed) Risk of falling. evaluation of the alternatives that were attempted prior use Inspections of the devices. No documentation was received for the requested documentation. Upon interview on 4/13/26 at 9:55 a.m. the Medical Director stated the facility was very aware of the restraint regulations. She stated the lap belts were	20520		05/11/2026

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20520	Continued from page 9 used for trunk control. The department teams meet daily to discuss removal of any alarms when the resident is ready. She was not aware that residents received the lap belt, bed alarm, and side rails on admission automatically. The facility was weighing the risks versus the benefits, and the facility tried to minimize the risk of falls. Alarms in residents with dementia can worsen the dementia, but the residents at the facility did not service a dementia population. The facility used the side rails as a tool for the residents to be more independent in their beds. R1 can remove his belt, not on command due to his delirium. Her expectation was the staff were following the guidelines of the facility assessments. The care plans were made for the staff to always ensure resident safety. She was not familiar with R2 or R3. She stated if R3 felt restricted with his bed alarm the facility should have tried an alternative to not restrain him. Upon interview on 4/13/26 at 10:26 a.m. the Administrator stated having the devices of the lap belt, the bed alarm, and the side rails were the standard of practice used by the facility and for safety of the residents. "It is the best practice". The facility admission policy titled Admission and Continued Stay Criteria dated 8/30/26 indicating. The Transitional Rehabilitation Program (TRP) provides holistic, comprehensive, inpatient neurological rehabilitation services to assist adults with disabilities and/or recovering from illness, injury, or surgery in gaining greater independence. The TRP is licensed as a skilled nursing facility and serves as a “bridge” or transitional setting between acute care and returning to a community living setting. During the program, people are required to actively participate in therapies/programming to accomplish their goals. Admissions staff complete a preadmission assessment to determine whether the potential client requires the specialized programming offered by the TRP and whether the TRP can meet the potential client’s needs. Care Specialties: Cerebrovascular Disorders (e.g., stroke, aneurysm) Spinal Cord Injury Brain Injury Neurovascular Disorder (e.g., spinal stroke) Other Complex Neurological/Neuromuscular disorders (e.g., Guillain-Barre Syndrome)	20520		05/11/2026

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20520	Continued from page 10 The policy did not indicate any information on restraints being used. A facility policy titled Restraints dated 1/23/24 indicated that Transitional Rehabilitation Program (TRP) supports the right of residents to be free from any physical or chemical restraint. Restraints have the potential to produce serious consequences, such as physical or psychological harm, and loss of dignity. Restraints will only be utilized as outlined in the State and Federal Nursing Home Resident's Bill of Rights (see addendum 1). POSITIONING AND SAFETY DEVICES Safety devices are used to enable the residents to attain or maintain their highest level of independent functioning and safety. The decision to use these aids and positioning devices is made through resident participation in individual assessment and care planning by the interdisciplinary team. They are used only with resident consent and under physician order and direction. The interdisciplinary team conducts an individual assessment/evaluation to determine the need for any positioning/potentially restraining/safety device. A care plan is developed to identify the residents' needs and parameters for use of the device, i.e., bed rails up at night so residents may use it to assist with turning. This care plan is reviewed at least quarterly and updated as needed. Prior to implementing the care plan, the nurse will review the risks and benefits of the use of the device with the resident. The resident, or if unable, the resident representative, signs the informed consent form and it is placed in the health record. Anytime a resident is using a positioning device, staff will assess the client's safety and comfort and will release the restraint as often as the resident requires for comfort, toileting, or other activities of daily living. Per the Nursing Home Residents' Bill of Rights, if a competent nursing home resident or their legal representative requests a restraint, staff will provide education regarding alternatives and the risks involved with restraint use. The facility will provide a physical restraint to a resident only upon receipt of informed consent and a written order from the attending physician that	20520		05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	**3915 GOLDEN VALLEY ROAD , GOLDEN VALLEY, Minnesota, 55422**

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20520	Continued from page 11 contains statements and determinations regarding medical symptoms and specifies the circumstances under which restraints are to be used. The restraint will be monitored and there will be documentation that procedures have been followed. Periodic reevaluation of the need for restraints will be conducted in consultation with the residents, family, and physicians. A physical restraint is any manual method, physical or mechanical device, equipment, or material that meets all the following criteria: • Is attached or adjacent to the resident's body. • Cannot be removed easily by the resident; and • Restricts the resident's freedom of movement or normal access to their body. Devices used in the facility may potentially be considered restraining include, but are not limited to, wheelchair and commode belts, lap trays, positioning devices, and bedside rails. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educate staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	20520		05/11/2026
21840	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 12 Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This LICENSURE REQUIREMENT is NOT MET as	21840	Courage Kenny Rehabilitation Institute - TRP treats each resident with respect and dignity and cares for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. R3 has discharged from the facility. Residents with potentially restraining devices will be reassessed to ensure no devices negatively impact the residents' rights. The policy regarding Resident Rights has been reviewed and no changes were necessary. The policy regarding restraints will be reviewed and revised as needed.	05/11/2026

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21840	Continued from page 12 evidenced by: Based on observation, interview and document review, the facility failed to provide respect and dignified treatment for 1 of 3 residents (R3) reviewed for dignity. R3 was given a bed alarm that R3 stated he did not consent to. The alarm limited his freedom of movement when he was in bed due to feeling startled by the loud sound of the alarm. In addition, he was anxious because he was concerned his alarm would bother residents near his room. Findings include: The facilities Consent Form for Restraints dated 2/2/26 indicated R3 signed giving consent for the medication trazodone and side rails on his bed. The bed alarm was not on the consent form. R3's admission minimum data set (MDS) dated 2/9/26 indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3 had mentioned his concerns to the staff. R3's care plan dated 2/4/26 indicated R3 had a bed alarm. The care plan did not indicate how often the alarm was to be used or the placement of the alarm under his body. Upon observation and interview on 4/9/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the lap belt alarm on his wheelchair and the alarm on his wheelchair when he left the unit (wander guard), but he was bothered by the bed alarm. He stated he did not consent to having the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. Upon interview on 4/9/26 at 11:05 a.m. the Nurse Practitioner stated he was aware that R3 had	21840	Continued from page 12 Staff will be re-educated regarding resident rights and potentially restraining devices, including informed consent and how alarms can impact residents psychosocially, as well as proper placement of bed alarms. Staff who have not completed the education by the completion date will complete it prior to beginning their next scheduled shift. The Administrator or designee will conduct weekly audits of residents with potentially restraining devices to ensure their rights are not negatively impacted. Audits will continue until the 5/28/26 QAPI meeting. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	05/11/2026

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21840	Continued from page 13 complained about his bed alarm and stated the staff reassured him the alarm was there for his safety and R3 was very cognitively impaired, so staff had to remind him often about his safety needs. Upon interview on 4/9/26 at 1:04 p.m. registered nurse, (RN)-B the nurse manager stated she was not aware that R3 had complaints with his bed alarm, she stated she would fix it immediately by having staff place the alarm up higher on his back, so he can move his legs easier while in bed and the alarm should not sound then unless he stood up. Upon interview on 4/9/26 at 2:06 p.m. the director of nursing, (DON) stated she had not heard of R3's allegations, however when the alarm stops when a resident stops moving their legs. Upon interview on 4/9/26 at 2:33 p.m. R3's Medical Provider stated he had not heard of R3's bed alarm complaint and was not certain how the staff should proceed as safety was the main concern. He thought the staff approach could be modified. Upon interview on 4/13/26 at 9:55 a.m. the Medical Director stated if R3 was having concerns with the bed alarm the facility should try an alternative and the facility should be addressing the concerns stating there is a need to keep him safe, catch him when we think he is getting out of bed, and respect his right to move. A facility policy titled Resident rights dated 9/30/25 indicated Planning and Implementing Care – The facility will: -Permit the resident/resident representative to participate in the development, revision, and implementation of a person-centered plan of care. This includes the right to identify individuals or roles to be included in the planning process, the right to participate in establishing the expected goals and outcomes of care, the right to sign the plan of care, and the right to be informed (in advance) of changes to the plan of care. Inform the resident/resident representative of the right to participate in their treatment and provide support to the resident/resident representative in doing so. This should include information concerning the care to be furnished and the type of	21840		05/11/2026

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21840	Continued from page 14 caregiver/professional to render services. -Ensure that the physician/practitioner or other professional has informed the resident in advance of the risks/benefits of proposed care, treatment and treatment alternatives/options and the right to choose same. Recognize the resident's right to request/refuse/discontinue treatment, to participate/refuse participation in experimental research, and to formulate an advance directive. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educate staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21840		05/11/2026

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F0000	INITIAL COMMENTS On 11/05/25 to 11/06/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H55196962C (2658411) with a deficiency cited at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		01/12/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Courage Kenny Rehabilitation Institute - TRP ensures that residents receive care consistent with professional standards of practice to prevent pressure ulcers, and that residents with pressure ulcers receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. R1’s care plan has been reviewed and revised. The pressure injury has healed. Any resident could potentially be affected. The records of residents at risk for pressure ulcers	01/12/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0686 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess pressure ulcer interventions and develop and implement new interventions to prevent pressure injuries for 1 of 1 resident (R1) who was identified as refusing repositioning on the overnight and acquired a new pressure sore. Findings Include: Definitions of pressure ulcer types according to National Pressure Ulcer Advisory Panel (NPUAP): Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. R1's quarterly Minimum Data Set (MDS) assessment dated 10/21/25, indicated diagnoses of traumatic spinal cord dysfunction, neurogenic bladder (condition where nerve damage from the brain, spinal cord, or peripheral nerves leads to a loss of bladder control) and quadriplegia (paralysis that affects all of a person’s limbs and body from the neck down). The MDS indicated R1 was cognitively intact and required extensive assistance of two with all activities of daily living. The MDS indicated R1 was at risk for developing pressure ulcers, no pressure ulcers and had pressure reducing device for his chair and bed. R1's Care Plan dated 10/27/25, indicated impaired skin integrity or potential for impaired skin integrity related to immobility. R1's Care Plan goal was to demonstrate a knowledge of risk factors and interventions for preventing skin breakdown with a revision date of 11/03/25. Interventions included assess condition of skin and document weekly, assist in keeping skin clean and dry, cleanse perineal area well with each incontinence, educate and encourage in the importance of meeting nutrition and hydration needs, educate and encourage participant in increasing skin tolerance. If resident refuses repositioning, provide education and document refusal and education provided (initiated 10/27/25). Replace on regular repositioning schedule (initiated 10/15/25), refer to physical therapy (PT) for positioning/seating/mobility needs (initiated 10/15/25), turn and reposition every two hours (initiated 10/15/25). The Care Plan further	F0686	Continued from page 1 will be reviewed and their care plans will be revised as needed, for example, if resident is refusing care. The standard work procedure for refusal of care will be reviewed and revised as needed. The standard work checklist for new wounds will be reviewed and revised as needed. Nursing staff will be educated regarding the regulation and this plan of correction, including the standard work for refusal of care and new wounds, as well as the importance of completing care that is ordered and accurately documenting such care. The Administrator or designee will conduct weekly audits to identify residents who refused care and ensure the standard work procedure was followed. Audits will continue until the 1/22/26 QAPI meeting. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	01/12/2026

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F0686 SS = D	Continued from page 2 indicated R1 had indwelling foley catheter and received a new leg bag every morning and new bed bag at night with staff to empty every four hours. R1's Treatment Administration Record (TAR) indicated on 10/26/25, to apply Mepilex (foam dressing) to sacrum (triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis and bilateral gluteal cleft) remove before showers and allow regular skin care. Cleanse with wound cleanser. Cover with large Mepilex. Change daily and as needed for dislodgement every evening shift. The TAR further directed staff to turn and reposition every 2-3 hours with a start date of 10/15/25. Progress Note dated 11/06/25, completed by register nurse (RN)-A indicated a pressure injury staged at Deep Tissue Pressure Ulcer/Injury: Persistent non-blanchable deep red, maroon or purple discoloration. The note indicated Wound history/plan: per client nursing had noted a red area on his coccyx last week. Floor nurse reported this to wound team on Friday 10/24/25, but was unable to be assessed as client was already up and in therapy for the day. Wound was seen over the weekend by nursing and WOC (registered nurse specializing in Wound, Ostomy, and Continence care) first thing on Monday. The note indicted R1 reports he occasionally declined repositioning at night. However, last Wednesday 10/22/25, R1 reports he spend all day in bed due to being sick. Referred to therapy for pressure mapping in bed and chair. The note indicated Wound Status Initial Assessment was on 10/27/25, coccyx 5 centimeters (cm) x1 cm x 0.1 cm and the left buttock 1.5 cm x 0 cm x 0 cm. right gluteal fold developed during stay on 10/24/25. Etiology: wound developed during stay and is from trauma possibly related to sling. Comments indicated as the coccyx wound is a deep tissue injury (DTI) it is impossible to know the extent of the injury before it surfaces and evolves. The coccyx is likely to evolve to a full thickness wound even with strict offloading. Education was provided to R1 about DTPI and the projected evolution. A photo was taken for R1 on his personal cell phone for his own records and education. During interview on 11/05/25 at 1:07 p.m., R1 stated he never had any skin issues at the two previous places he was at for the past 60 days and then arrived at this facility and within 11 days developed a pressure ulcer. R1 stated he did refuse his first or second night to be repositioned due to the night shift staff being so loud with his roommate when providing cares and he was so tired and did not	F0686		01/12/2026

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F0686 SS = D	Continued from page 3 want to be bothered. R1 stated he also got upset with one of the night NAR's when she was attempting to take his shirt off and felt she hurt him and requested for her to never come back in his room. R1 stated now all of the aides are saying he is refusing cares and staff which he feels is not true. R1 stated he recalled on 10/22/25, he was not feeling well and went to bed around 3:00 p.m. and slept until 11:00 a.m. the following day and does not recall any staff attempting to reposition him or offering to. R1 stated he feels that was when the pressure ulcer developed. R1 stated a NAR while changing him informed him he had a sore on 10/24/25, and it was not looked at by the nurse until 10/27/25 and was informed it was a pressure ulcer. R1 stated his pressure ulcer was looked at again by the wound nurse on 10/31/25, and I was told the dressing would be changed every evening over the weekend and no one came to change it. R1 further stated NAR-B worked Monday morning noticed drainage and told me she would inform the nurse working. That was when I asked for it (dressing) to be changed in the morning. During interview on 11/06/25 at 8:45 a.m., nursing assistant (NA)-A stated she worked the night shift with R1, and prior to him getting his pressure ulcer he would refuse to be turned and repositioned all of the time and would only allow to be turned usually one time during the night. NA-A stated after R1 received the pressure ulcer, he would usually let us turn and reposition him every three hours during the night. During interview on 11/06/25 at 9:58 a.m. registered nurse (RN)-A stated she does the wound rounds and completed R1's admission wound assessment on 10/14/25. RN-A indicated she had no concerns with R1’s skin. RN-A stated she provided R1 with a new bed which was a adapt, group three wound mattress with alternating air. On 10/24/25 at 9:30 a.m., RN-A stated she was informed there was wound concern and needs to know prior to her wound rounds at 8:00 a.m. which residents she is to see. RN-A stated she was told R1 was at therapy and instructed the nurse to let her know when he is in bed and she would look at his skin. RN-A stated the nurse never got back to her and at around 6:00 p.m. she was able to see R1 who was busy all day with therapy and at that time was up in his chair and had visitors. RN-A stated she set up arrangements to look at his skin right away on Monday morning 10/27/25, that was when she saw he had a deep tissue injury (DTI) on his coccyx. RN-A stated R1 had a history of refusing to be repositioned during the night and was never informed of this and unfortunately the staff did	F0686		01/12/2026

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F0686 SS = D	Continued from page 4 not document this or the risks vs. benefits although knowing he was aware. RN-A stated R1 was on a every three to four hour turning and repositioning program and was immediately changed to a strict every two-hour schedule and after R1 saw the picture of his wound he has been compliant to his schedule. In addition, RN-A stated the nurse that originally found R1's wound on 10/24/25, should have filled out the proper paperwork and at a minimum filled out a progress note describing the new skin area which she failed to do. During observation and interview on 11/06/25 at 11:45 a.m., RN-A removed R1's dressings and indicated his deep tissue injury on his coccyx now had slough and some dead tissue. RN-A stated this would be expected with a DTI. R1 questioned RN-A if his dressing changes were to be completed daily over the weekend after she changed the dressing on Friday 10/31/25. RN-A informed R1 they were to be changed daily. RNA-A stated the dressing had not been changed until Monday 11/03/25, by the dayshift nurse. During interview on 11/06/25 at 12:46 p.m., R1's nurse practitioner (NP) stated she was informed on R1's pressure ulcer on Monday 10/27/25, when RN-A observed the wound and R1 was pressure mapped for pressure areas. NP further stated she was made aware after the finding of the pressure ulcer R1 was not allowing staff to turn and reposition him during the night. During interview on 11/06/25 at 2:57 p.m., RN-B stated he worked the weekend of 11/01/25 to 11/02/25 and had several issues going on that weekend with other residents with blood pressures and helping the nursing assistants. RN-B stated he screwed up and didn't get the dressing change done and just didn't get the dressing changes completed. RN-B stated the acuity has increased and staffing can be a component on his shift. During interview on 11/06/25 at 3:14 p.m., RN-A stated the dressing change was to be completed every evening and she will follow up with RN-B. RN-A stated for pressure injuries that are not significant in depth the dressings can be left on for three to five days but with R1 she would like the dressing changed daily so the wound could be monitored and assessed. RN-A stated she did expect some necrosis (dead tissue) on the wound due to natural evolution of the DTI and about 75% of DTI become necrotic. The Facility New Wound or Worsening Skin Concern	F0686		01/12/2026

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F0686 SS = D	Continued from page 5 undated, indicated nursing is to observe and assess the area of concern. Note the location, measurements, depth, drainage and appearance. Determine the best treatment based on the "Wound and Skin Care Guidelines" and place a nursing order for that treatment. Identify the potential causes for the wound. Document your assessment and intervention's initiated on a "skin/wound" progress note. Fill out a wound tracker form and email to team to communicate the presence of a skin concern of existing wounds. Notify responsible party/POA, with client approval, if they do not have a guardian and put completed check list in the DON mailbox.	F0686		01/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	**3915 GOLDEN VALLEY ROAD , GOLDEN VALLEY, Minnesota, 55422**

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F0000	INITIAL COMMENTS On 4/7/26 – 4/13/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H55191093C/MN2971520 with a deficiency issued at F689. Deficient practice was identified related to incidental finding at F550, F604, F657, F846, and F909. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to identify environmental risks for stairwell doors that had nonfunctioning alarms, disabled locks, and failed to adequately supervise 1 of 3 residents (R1) through the remote monitoring system. This resulted in immediate jeopardy for 1 of 3 residents (R1) reviewed who opened a stairwell access door, wheeled through the door, and fell six stairs while secured by a lap belt in his wheelchair. R1 sustained a hematoma (localized collected of clotted or partially clotted blood outside causing swelling, pain, and skin discoloration) and was sent to the emergency department for evaluation. The above findings constituted substandard quality of care, and an extended survey was conducted from 4/9/26 to 4/13/26. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0000	Continued from page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to identify environmental risks for stairwell doors that had nonfunctioning alarms, disabled locks, and failed to adequately supervise 1 of 3 residents (R1) through the remote monitoring system. This resulted in immediate jeopardy for 1 of 3 residents (R1) who opened a stairwell access door, wheeled through the door, and fell down six stairs while secured by a lap belt in his wheelchair. R1 sustained a hematoma (localized collected of clotted or partially clotted blood outside causing swelling, pain, and skin discoloration) and was sent to the emergency department for evaluation. In addition, the facility failed to have a system in place for routine checks on the fire door alarm system to ensure the employee badges and the resident wander guard (an alarm placed on or near the resident's body to alarm when they attempt to leave the unit) were in working order. This had the potential to affect all residents who resided in the unit. The Immediate Jeopardy (IJ) began on 4/1/26 when R1 fell down the facilities stairwell. The Administrator and the director of nursing were notified of the immediate jeopardy on 4/7/26 at 5:15 p.m. The immediate jeopardy was removed on 4/9/23 at 5:43 p.m., but noncompliance remained at the lower scope and severity, level 2, F – widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F0689		

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F0689 SS = SQC-J	Continued from page 2 Findings include: Video surveillance of the incident on 4/1/26 at 4:06 p.m. showed R1 was coming out of his room in his wheelchair headed toward the emergency exit door. He pushed open the door with his left arm, going through the door placed both hands on either the brakes on his wheelchair or the arm rests then the emergency door closed. Two staff were walking into the nursing station office at 4:08 p.m. At 4:12 p.m. the staff walked to the emergency door, opened the door, and appeared to be calling for help. The video surveillance had no auditory recording. Upon observation and interview on 4/7/26 at 12:17 p.m. R1 was seated in his wheelchair in his room with a 1:1 staff. R1 recalled the fall stating he fell down about seven steps, but that is all he could remember. He did not recall whether he was in his wheelchair or not. Upon observation and interview with the maintenance engineer on 4/7/26 at 1:45 p.m. the maintenance engineer used his employee key card to open the door to observe the stairwell where R1 fell. The door opened to six stairs going down and stairs going up. After viewing the stairwell, the surveyor pushed onto the door, the door opened with no alarm sounding or badge use. The maintenance engineer stated that it was a concern, and he would be bringing it up at the following intradisciplinary team meeting the following day. He stated he was not aware that R1 had gotten through the door and fallen down the stairs. He was going to speak with his supervisor, who was at another location and see if he should secure the door until the facility could fix the alarm. R1’s consent to remote observation dated 3/11/26 indicated R1 would be monitored remotely via a remote observation video and audio device that is monitored 24 hours a day by a trained observation technologist within the facilities health system. R1’s admission Minimum Data Set (MDS) dated 3/18/26, indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was	F0689		

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F0689 SS = SQC-J	Continued from page 3 always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke. R1's care plan dated 3/23/26 indicated R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. R1's care plan did not include staff supervision until 4/1/26 following his fall. R1's care plan did not include R1 had a wander guard. R1's provider orders dated 4/1/26 indicated to discontinue the remote observation and start hourly rounding. R1's post-fall summary undated, indicated staff responded to a wander guard at the stairs, found R1 face down in the stairs with his wheelchair attached. R1 hit his head with a hematoma (a localized collection of clotted or pooled outside blood vessels caused by trauma, surgery or underlying vascular injury) forming. Emergency medical services were called and R1 was transferred to the hospital. R1's hospital after visit summary dated 4/1/26 indicated R1 was seen for a fall with a hematoma (localized collected of clotted or partially clotted blood outside causing swelling, pain, and skin discoloration) of the frontal scalp. R1's subsequent Transitional Rehabilitation Program note dated 4/2/26 indicated on 4/1/26 R1 was able to open a door to the stairway and fell down the first flight of stairs while still strapped to his wheelchair. He was sent for emergency evaluation. While in the Emergency Department he underwent a trauma workup and no significant injuries were found, besides a contusion on the front of his right forehead. He was set back to the facility that evening. At that time, he was placed on a 1:1 (a staff member would always be with R1). Prior to this he had remote observation. Upon interview on 4/7/26 at 2:00 p.m. the maintenance supervisor stated that the facility had not had the alarm in the stairwell in working order	F0689		

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F0689 SS = SQC-J	Continued from page 4 for months because the door did not need to be secure because the residents used the video surveillance system or the wander guard system (alarm placed on the resident that sounds an alarm when the resident is near a door). He was not aware of R1's fall. Upon interview on 4/7/26 at 2:31 p.m. R1's family member (FM)-A stated he was told that R1's remote observation alarm was delayed so R1 got out of his room without staff's awareness and by the time staff found him he had fallen down the stairs. When he visited staff would check on him, however not on a regular basis. (FM)-A used the unarmed door when he would visit R1 to enter and leave the facility, so he believed R1 thought that was his way out. Upon interview on 4/8/26 at 10:15 a.m. registered nurse (RN)-C stated R1's supervision was through the remote monitoring since the remote system watches residents 24 hours a day and redirects them for the staff on the unit. He would visualize R1 when he walks by his room, otherwise at shift change staff check in on all their residents. (RN)-C stated he was aware that the alarm on the door did not sound, and he did not have to use his badge to get through the door, he could not recall how long the door had been unarmed. (RN)-C did not notify anyone about the door, but management and other staff were able to walk through the door, so he did not think it was a concern. Upon interview on 4/8/26 at 10:35 a.m. the health unit coordinator (HUC) stated she was aware the door was unarmed. She did not report it to maintenance because she saw management use the door without their badge, so she assumed there were no concerns. Upon interview on 4/8/26 at 11:11 a.m. nursing assistant NA-A stated the supervision for R1 was the remote observation system because R1 was unable to use his call light to call for help. There were no criteria for checking on him and it would be unrealistic to check on him hourly because within the hour he could have fallen. She was unaware that the door was unarmed. Upon interview on 4/8/26 at 11:25 a.m. the security supervisor stated he came to the facility to check on the door. He stated the alarm had been turned off in	F0689		

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F0689 SS = SQC-J	Continued from page 5 March and turned back on 4/1/26. He stated he was not certain how the facility checked for the doors to be working. He could see that multiple staff continued to use their badge since the alarm was shut off. Upon interview on 4/8/26 at 12:25 p.m. the offsite remote observation supervisor stated her team did an investigation, and they found their team member did not follow the work standard. The technician who was watching R1 walked away from his desk and within a few seconds R1 had left his room. When the technician saw R1 was not in his room he called the charge nurse at the facility. The protocol should have been to have sounded the remote alarm so the facility would have heard the alarm and searched for R1 more quickly. Upon interview on 4/8/26 at 1:36 p.m. RN-D stated R1's supervision was the remote observation, the chair and bed alarms. He was wondering why he no longer needed to use his badge for the door, but thought management had made a change. Upon interview on 4/8/26 at 1:48 p.m. RN-E stated a little after 4:10 on 4/1/26 he received a call from the remote observation technician and what he thought the technician said was that R1 had left his room with a facility staff member so RN-E was not concerned. A few seconds later he heard a wander guard alarm sound. He ran to the door and found R1 had fallen down the first set of stairs in the stair well. R1 was face down with his wheelchair on top of him. He had to cut R1's lap belt off him. R1 was conscious, emergency medical services were called and R1 was taken to the hospital. RN-E stated after R1 was transferred to the hospital he was informed by NA-B that R1 had increased agitation and had attempted to leave the building the prior day. Upon interview on 4/8/26 at 3:10 p.m. NA-B stated she worked the evening R1 fell. She also responded to the wander guard alarm and found R1 face down with his wheelchair attached to him. R1 was supervised with the remote observation and his alarms, but they failed him on 4/1/26. Upon interview on 4/9/26 at 11:05 a.m. R1's Nurse Practitioner (NP) stated the facility uses multiple devices for all the residents for their safety. He stated after the fall he ordered staff to also	F0689		

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F0689 SS = SQC-J	Continued from page 6 supervise R1. Upon interview on 4/9/26 at 1:04 p.m. RN-B stated R1's supervision was the remote observation unit, and he should have been on hourly rounding as well. The facility was thinking of stopping the remote observation as they felt it was agitating R1 more. The wander guard alarm was started prior to the fall on 4/1/26 due to increased agitation and R1 attempting to elope out the same door the previous day. RN-B was not aware the door alarm had been turned off. Upon interview on 4/9/26 at R1's medical provider stated he was aware that R1 had gotten through the door and fell with his wheelchair attached to him. He could not be certain how having R1 belted into his chair could have changed the fall. He was not aware the emergency alarm on the door was not working and if they could have prevented the fall either. He stated the door needed to be fixed and even with all the devices staff should also be supervising the residents. Upon interview on 4/13/26 at 10:26 a.m. the Administrator stated the staff supervise the residents even with the use of the remote observation and alarms. She believed R1 was being supervised every hour by staff. Secure Care Products (wander guard) user manual with a revision date of 11/16/07 indicated Secure Care's software, parts and products have been designed to augment a facility's reasonable procedures for protecting residents, patients, and infants. However, no system or combination of procedures and equipment can eliminate all risk or assure complete security. Secure Care's system is not intended as a substitute for the careful identification and monitoring of residents, patients, and infants by a facility's professional staff. The manual indicated that weekly testing of wandering patients should be tested to make sure the transmitter is working. -Monthly testing should be performed for the fire alarm release feature. -The annual service was recommended to be sure the battery was replaced. -Onguard user guide (the employee badge alarm	F0689		

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F0689 SS = SQC-J	Continued from page 7 locks) dated 1/2005 indicated how to set up the alarms and how to check the arms but did not indicate how often a facility should be checking the alarms. Allegion user guide dated 2021 indicated The Von Duprin Chexit device is designed for controlled egress applications. It meets both life safety and security needs, as well as the requirements of NFPA101 for “Special Locking Arrangement” and IBC “Special Egress-Control Devices”. All control inputs, auxiliary locking, local alarm and remote signaling outputs are self-contained in the Chexit assembly. Numerous field configurable options allow the device to be customized for the specific code or application requirements. The standard Chexit device sounds an alarm and keeps the door secured for 15 seconds following an exit attempt with immediate release upon fire. The manual indicated how to test the powerup, the delayed egress and an advanced function test, however, did not indicate how often a facility should be testing the devices. Policies regarding accidents and equipment inspections were requested, however none was received. The Immediate Jeopardy (IJ) began on 4/1/26 when R1 fell down the facilities stairwell. The Administrator and the director of nursing were notified of the immediate jeopardy on 4/7/26 at 5:15 p.m. The immediate jeopardy was removed on 4/9/23 at 5:43 p.m., when the facility trained all staff about reporting when they are aware a door is unarmed. The facility made plans to make the second emergency door into an armed door to mirror the door R1 went out of. The facility placed signs on the unarmed door and used remote observation 24 hours a day to alarm if a resident or staff attempted to use the door. Staff were educated to respond immediately when they heard the remote alarm sound. The facility audited staff to ensure staff responded. but noncompliance remained at the lower scope and severity, level 2, F – widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F0689		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F0550		

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F0550 SS = D	Continued from page 8 The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide respect and dignified treatment for 1 of 3 residents (R3) reviewed for dignity. R3 was given a bed alarm that R3 stated he did not consent to. The alarm limited his freedom of movement when he was in bed due to feeling startled by the loud sound of the alarm. In addition, he was anxious because he was concerned his alarm would bother residents near his room.	F0550		

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F0550 SS = D	Continued from page 9 Findings include: The facilities Consent Form for Restraints dated 2/2/26 indicated R3 signed giving consent for the medication trazodone and side rails on his bed. The bed alarm was not on the consent form. R3's admission minimum data set (MDS) dated 2/9/26 indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3 had mentioned his concerns to the staff. R3's care plan dated 2/4/26 indicated R3 had a bed alarm. The care plan did not indicate how often the alarm was to be used or the placement of the alarm under his body. Upon observation and interview on 4/9/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the lap belt alarm on his wheelchair and the alarm on his wheelchair when he left the unit (wander guard), but he was bothered by the bed alarm. He stated he did not consent to having the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. Upon interview on 4/9/26 at 11:05 a.m. the Nurse Practitioner stated he was aware that R3 had complained about his bed alarm and stated the staff reassured him the alarm was there for his safety and R3 was very cognitively impaired, so staff had to remind him often about his safety needs. Upon interview on 4/9/26 at 1:04 p.m. registered nurse, (RN)-B the nurse manager stated she was not aware that R3 had complaints with his bed alarm, she stated she would fix it immediately by having staff place the alarm up higher on his back, so he can move his legs easier while in bed and the alarm	F0550		

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F0550 SS = D	Continued from page 10 should not sound then unless he stood up. Upon interview on 4/9/26 at 2:06 p.m. the director of nursing, (DON) stated she had not heard of R3's allegations, however when the alarm stops when a resident stops moving their legs. Upon interview on 4/9/26 at 2:33 p.m. R3's Medical Provider stated he had not heard of R3's bed alarm complaint and was not certain how the staff should proceed as safety was the main concern. He thought the staff approach could be modified. Upon interview on 4/13/26 at 9:55 a.m. the Medical Director stated if R3 was having concerns with the bed alarm the facility should try an alternative and the facility should be addressing the concerns stating there is a need to keep him safe, catch him when we think he is getting out of bed, and respect his right to move. A facility policy titled Resident rights dated 9/30/25 indicated Planning and Implementing Care – The facility will: -Permit the resident/resident representative to participate in the development, revision, and implementation of a person-centered plan of care. This includes the right to identify individuals or roles to be included in the planning process, the right to participate in establishing the expected goals and outcomes of care, the right to sign the plan of care, and the right to be informed (in advance) of changes to the plan of care. Inform the resident/resident representative of the right to participate in their treatment and provide support to the resident/resident representative in doing so. This should include information concerning the care to be furnished and the type of caregiver/professional to render services. -Ensure that the physician/practitioner or other professional has informed the resident in advance of the risks/benefits of proposed care, treatment and treatment alternatives/options and the right to choose same. Recognize the resident's right to request/refuse/discontinue treatment, to participate/refuse participation in experimental research, and to formulate an advance directive.	F0550		

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F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation interview and document review, the facility failed to implement a process to assess for, determine medical symptoms, obtain an order prior to use, assess for use of the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints for 3 of 3 residents (R1, R2, R3) reviewed for use of physical restraints. Findings include: Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 Section P: Restraints and Alarms	F0604		

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F0604 SS = D	Continued from page 12 indicated physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident. Physical restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers. Upon observation and interview on 4/7/26 at 12:17 p.m., R1 was observed to have bilateral quarter side rails at the head of his bed and three-quarter length side rails at the foot of his bed. R1 was seated in his wheelchair with an alarmed seat belt around his waist. On the back of his chair, he had a wander guard bracelet attached to his wheelchair. R1 was not certain what the side rails on his bed were for. He stated that the bed was the bed he slept in. He could not take the lap belt off by himself. He then started speaking incoherently about working in his car in his shop. R1's Physical Device assessment dated 3/11/26, indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability to appropriately use the device. The device did not restrict voluntary freedom of moment or prevent access to any body part. He understood the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried.	F0604		

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F0604 SS = D	Continued from page 13 R1's admission Minimum Data Set (MDS) dated 3/18/26, indicated R1 had a brief inventory of mental status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). R1's care plan dated 3/23/26, indicated R1 may use half side rails for positioning and safety when in bed. R1. The side rails were to be used when he was in bed to allow for safe positioning due to spasms. His care plan did not indicate there were side rails attached to the foot of his bed or any interventions for those. R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. The care plan did not indicate when the staff was to release the belt to give R1 freedom of movement. R1 had a wander guard (an electronic security system that uses a bracelet on a resident that alarms when the resident tries to wander outside the facility) that was not identified on the care plan or any interventions for use. Upon observation on 4/8/26 at 8:55 a.m., R2 was in bed, she had bilateral quarter side rails at the head of her bed. She had a seat belt alarm in her wheelchair and a wander guard bracelet attached to the back of her wheelchair. When she was dressed and moved to her wheelchair, she was unable to move her right arm and was unable to remove the lap belt on her own. R2 could not speak, she would nod yes and no to questions. R2's Physical Device Assessment dated 2/27/26, indicated R2 had quarter size left and right-side rails. She was able to demonstrate the ability to use the device appropriately and they did not restrict her voluntary freedom of movement or prevent access to a body part. Her decision maker understood the risk and benefits. R2's symptoms were weakness, impaired mobility, hemiplegia, rehab, to facilitate independence. Her diagnoses of CVA and no less restrictive devices were tried.	F0604		

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F0604 SS = D	Continued from page 14 R2's admission MDS dated 3/6/26 indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2's BIMS score was 00 which indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent on toileting and transfers. Her pertinent diagnoses were cerebral infarction (stroke), aphasia (impairment caused by brain damage that impairs a person's ability to process language, speak, read, write, and understand speech), dysphagia (difficulty swallowing), symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2's care plan dated 2/27/26 did not indicate R2 had bilateral quarter sized side rails, the seat belt alarm, or the wander guard. Upon observation and interview on 4/8/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the alarm belt on his wheelchair and the alarm on his wheelchair when he left the unit, but he was bothered by the bed alarm. He stated he did not consent to put the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. R3's Physical Device Assessment dated 2/2/26 indicated R3 had right and left quarter sized rails on his bed. He was able to demonstrate the ability to use the device appropriately and it did not restrict any voluntary freedom of movement or prevent access to any body part. Client and decision maker did not say they understood the risk and benefits. R3's symptoms were impaired judgement and hemiplegia. R3's diagnosis was a CVA, and no less restrictive devices were tried. R3's summary indicated quarter side rails on bed to help with turning and reposition. R3's admission MDS dated 2/9/26, indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for	F0604		

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F0604 SS = D	Continued from page 15 toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's care plan dated 2/4/26 indicated R3 had a bed alarm, seat belt alarm to be on when in his wheelchair to aide in trunk support, grab bars/bedrails. Email correspondence following the survey on 4/15/26 from the Administrator revealed a facility in-house email chain indicated RN-F interviewed R1, R2 and R3 on 4/10/26 at 3:53 p.m. see below: R3- says he likes and uses the bedrail, able to take off his seatbelt, thinks the seat belt is a good idea, doesn't like the bed or seatbelt alarms because there are too many false alarms, he would be ok with them if they only alarmed when he actually needed them to, but they alarm when he just raises his leg. R1 - says he likes and uses the bedrails, was unable to take off his seatbelt for me, even with prompting, says he hates the seatbelt and the seatbelt alarm and bed alarm. R2 - nodded yes that she likes and uses the bed rails, was able to take off her seatbelt when I asked her to show me, nodded yes that she likes the seat belt, and the bed and the seatbelt alarms. Email correspondence dated 4/11/26 from the Administrator to PT-A indicated R1, R2 and R3 all used the bedrails for either repositioning or transferring. The facility was going to find R1 a different type of belt that R1 could remove. R1 was still on a 1:1 (one staff with a resident all the time) therefore an alarm was not necessary. Email correspondence dated 4/12/26 email from PT-A to the administrator indicated she attempted to see R1 twice on Saturday 4/11/26 the first attempt he was too agitated and second attempt R1 had visitors. She would follow up to make sure this happens on Monday (4/13/26). She recommended 1:1 staff needed to are aware the change will happen. She indicated she was concerned if R1 could easily be able to get his seat belt off, he	F0604		

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F0604 SS = D	Continued from page 16 would stand up even with someone in the room and likely fall. She indicated she understood this is part of the state recommendation however she wanted to make sure they had a plan to keep him and staff safe. Upon interview on 4/8/26 at 11:11 a.m., nursing assistant (NA)-A stated she had never been told to release any of the residents on the unit who wore lap belts. R1 could remove his belt, because he often did it and staff would have to response, but he did not understand what the belt was for. R2 had never attempted to stand up or remove her alarm when NA-A had worked with her. R3 had complained about his bed alarm and was told by staff it was for his safety. Upon interview on 4/8/26 at 11:59 a.m. physical therapist (PT)-A stated it was the facilities standard of practice for anyone with a brain injury to get a lap belt and side rails placed upon admission. The reason for the restraints was because the residents could try to self-transfer and fall. Some residents need the lap belt because they are unable to understand how to call the nurse for help, if they release the belt the alarm would sound, and staff would assist. R1 could remove his belt, but he cannot remember things from day to day, was the reason he required the lap belt. The facility did not have it care planned that staff were to remove the seat belt as R1 could only walk with therapy assistance. R1 could follow only one step commands, he would become tired and then agitated so he could fall. Residents have side rails for turning and repositions and our beds are narrow, so the residents needed the rails to keep them safe from falling out of bed. Upon interview on 4/8/29 at 1:48 p.m. registered nurse (RN)-E stated all residents have the lap belts and side rails upon admission until they are assessed by therapy services. Nursing had nothing to do with any equipment assessments, Occupational and Physical Therapy completed equipment assessments. Upon interview 4/8/26 at 2:29 p.m. PT-B stated upon admission the residents did receive the lap belt and the side rails. The brain injury diagnosis the restraints were used was usually for forgetfulness and impulsiveness and the spinal cord injury residents diagnoses for the restraints for trunk	F0604		

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F0604 SS = D	Continued from page 17 support. Therapy assessed the residents usually within the first day of admission and would then assess the appropriateness of the lap belt and side rails. R1 was recommended to have the 24-hour remote observation, the seat lap belt, the bed alarm, and the side rails. R1 did not have the cognition to make himself safe so therapy implemented the safety devices. If R1 were to stand-up he would fall. The alarms were treating R1's impulsiveness. The seat belt alarm, the side rails, and the bed alarms were the least restrictive devices. Laps belts were not considered a restraint if the resident can remove it by themselves or ask someone else to remove it for them. The facility had different levels of belts, some disengaged easier than others. All facilities departments meet for daily interdepartmental meetings and discuss the needs of the residents. (PT)-B believed R2 could remove her lap belt, she stated if she cannot even though she is unable to speak, she could use her call light and could call for a nurse to assist her. R3 required the seat belt, side rails, and bed alarm due to falls. "We need to have as many noises as possible, so we can get to the residents as soon as possible." Upon interview on 4/8/26 at 3:10 p.m. NA-A stated R1 took off his bed multiple times a shift. He did not understand what the belt was for, he would fidget with the belt when he was agitated. The staff only removed the lap belts for R1, R2, and R3 when they needed to use the bathroom or went to bed. Upon interview on 4/9/26 at 11:05 a.m. the nurse practitioner (NP) stated the lap belts; the side rails and the bed alarms were safety for the residents. Without the devices residents would fall. He was not certain what assessments therapy performed for the residents. He was not certain if any less restrictive devices had been attempted or what ongoing monitoring looked like. He did not order any of the devices. He signed whatever therapy assessed. He stated the medical diagnoses for R1, R2 and R3 would be cognitive concerns and impulsiveness. The residents did not have good judgement, which was the reason they had the devices, so they did not fall. Upon interview on 4/9/26 at 1:04 p.m. RN-B stated the standard process for admitting residents with a brain injury was to get a bed alarm, lap belt, and side rails. Therapy completed all the device assessments, no nursing. She did not have an admission protocol document to offer.	F0604		

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F0604 SS = D	Continued from page 18 Upon interview on 4/9/26 at 2:06 p.m. the director of nursing stated the benefits outweighed the risk with the lap belt, the side rails, and the alarm. A request was made during the interview for the DON to provide the following documentation for R1, R2 and R3 regarding the restraint use: Medical diagnosis, conditions, symptoms, and/or behavioral symptoms. Size and weight. Sleep habits. Medication(s). Acute medical or surgical interventions. Underlying medical conditions. Existence of delirium. Ability to toilet safely. Cognition. Communication Mobility (in and out of bed) Risk of falling. evaluation of the alternatives that were attempted prior use Inspections of the devices. No documentation was received for the requested documentation. Upon interview on 4/13/26 at 9:55 a.m. the Medical Director stated the facility was very aware of the restraint regulations. She stated the lap belts were used for trunk control. The department teams meet daily to discuss removal of any alarms when the resident is ready. She was not aware that residents received the lap belt, bed alarm, and side rails on admission automatically. The facility was weighing the risks versus the benefits, and the facility tried to minimize the risk of falls. Alarms in residents with dementia can worsen the dementia, but the residents at the facility did not service a dementia population. The facility used the side rails as a tool for the residents to be more independent in their beds. R1	F0604		

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F0604 SS = D	Continued from page 19 can remove his belt, not on command due to his delirium. Her expectation was the staff were following the guidelines of the facility assessments. The care plans were made for the staff to always ensure resident safety. She was not familiar with R2 or R3. She stated if R3 felt restricted with his bed alarm the facility should have tried an alternative to not restrain him. Upon interview on 4/13/26 at 10:26 a.m. the Administrator stated having the devices of the lap belt, the bed alarm, and the side rails were the standard of practice used by the facility and for safety of the residents. "It is the best practice". The facility admission policy titled Admission and Continued Stay Criteria dated 8/30/26 indicating. The Transitional Rehabilitation Program (TRP) provides holistic, comprehensive, inpatient neurological rehabilitation services to assist adults with disabilities and/or recovering from illness, injury, or surgery in gaining greater independence. The TRP is licensed as a skilled nursing facility and serves as a “bridge” or transitional setting between acute care and returning to a community living setting. During the program, people are required to actively participate in therapies/programming to accomplish their goals. Admissions staff complete a preadmission assessment to determine whether the potential client requires the specialized programming offered by the TRP and whether the TRP can meet the potential client’s needs. Care Specialties: Cerebrovascular Disorders (e.g., stroke, aneurysm) Spinal Cord Injury Brain Injury Neurovascular Disorder (e.g., spinal stroke) Other Complex Neurological/Neuromuscular disorders (e.g., Guillain-Barre Syndrome) The policy did not indicate any information on restraints being used. A facility policy titled Restraints dated 1/23/24 indicated that Transitional Rehabilitation Program (TRP) supports the right of residents to be free from any physical or chemical restraint. Restraints have the potential to produce serious consequences, such as physical or psychological harm, and loss of	F0604		

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F0604 SS = D	Continued from page 20 dignity. Restraints will only be utilized as outlined in the State and Federal Nursing Home Resident's Bill of Rights (see addendum 1). POSITIONING AND SAFETY DEVICES Safety devices are used to enable the residents to attain or maintain their highest level of independent functioning and safety. The decision to use these aids and positioning devices is made through resident participation in individual assessment and care planning by the interdisciplinary team. They are used only with resident consent and under physician order and direction. The interdisciplinary team conducts an individual assessment/evaluation to determine the need for any positioning/potentially restraining/safety device. A care plan is developed to identify the residents' needs and parameters for use of the device, i.e., bed rails up at night so residents may use it to assist with turning. This care plan is reviewed at least quarterly and updated as needed. Prior to implementing the care plan, the nurse will review the risks and benefits of the use of the device with the resident. The resident, or if unable, the resident representative, signs the informed consent form and it is placed in the health record. Anytime a resident is using a positioning device, staff will assess the client's safety and comfort and will release the restraint as often as the resident requires for comfort, toileting, or other activities of daily living. Per the Nursing Home Residents' Bill of Rights, if a competent nursing home resident or their legal representative requests a restraint, staff will provide education regarding alternatives and the risks involved with restraint use. The facility will provide a physical restraint to a resident only upon receipt of informed consent and a written order from the attending physician that contains statements and determinations regarding medical symptoms and specifies the circumstances under which restraints are to be used. The restraint will be monitored and there will be documentation that procedures have been followed. Periodic reevaluation of the need for restraints will be conducted in consultation with the residents, family, and physicians. A physical restraint is any manual method, physical or mechanical device,	F0604		

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F0604 SS = D	Continued from page 21 equipment, or material that meets all the following criteria: • Is attached or adjacent to the resident's body. • Cannot be removed easily by the resident; and • Restricts the resident's freedom of movement or normal access to their body. Devices used in the facility may potentially be considered restraining include, but are not limited to, wheelchair and commode belts, lap trays, positioning devices, and bedside rails.	F0604		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to develop a person-centered care	F0657		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	**3915 GOLDEN VALLEY ROAD , GOLDEN VALLEY, Minnesota, 55422**

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F0657 SS = D	Continued from page 22 plan that included all the medical devices in use and develop interventions for the safe use of the devices for 3 of 3 residents (R1, R2, and R3) who were reviewed for care plan development. Findings include: Upon observation and interview on 4/7/26 at 12:17 p.m. R1 was observed to have bilateral quarter side rails at the head of his bed and three-quarter length side rails at the foot of his bed. R1 was seated in his wheelchair with an alarmed seat belt around his waist on the back of his chair he had a wander guard bracelet attached to his wheelchair. R1’s admission Minimum Data Set (MDS) dated 3/18/26 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1’s pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). R1’s care plan dated 3/23/26 indicated R1 may use half side rails for positioning and safety when in bed. R1. The side rails were to be sued when he was in bed to allow for safe positioning due to spasms. His care plan did not indicate the side rails attached to the foot of his bed or any interventions for them. R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. The care plan did not indicate when the staff was to release the belt to give R1 freedom of movement. R1 had a wander guard (an electronic security system that uses a bracelet on a resident that alarms when the resident tries to wander outside the facility) that was not identified on the care plan or any intervention. Upon observation on 4/9/26 at 8:55 a.m. R2 was in bed, she had bilateral quarter side rails at the head of her bed, she had a seat belt alarm in her wheelchair and a wander guard bracelet attached to her wheelchair.	F0657		

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F0657 SS = D	Continued from page 23 R2's admission MDS dated 3/6/26 indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2's BIMS score was 00 indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent in toileting and transfers. Her pertinent diagnoses were cerebral infarction, aphasia, dysphagia, symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2's care plan dated 2/27/26 did not indicate R2 had bilateral quarter sized side rails, the seat belt alarm, or the wander guard. Upon observation and interview on 4/8/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the alarm belt on his wheelchair and the alarm on his wheelchair when he left the unit, but he was bothered by the bed alarm. He stated he did not consent to put the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. R3's admission MDS dated 2/9/26 indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction (stroke), dysphagia (difficulty swallowing) aphasia (impairment of a person's ability to process language, speak, read, write, and understand speech), abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's care plan dated 2/4/26 indicated R3 had a bed alarm, seat belt alarm to be on when in his wheelchair to aide in trunk support, grab bars/bedrails. Upon interview on 4/9/26 at 9:12 a.m. nursing	F0657		

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F0657 SS = D	Continued from page 24 assistant (NA)-A stated even though R2's devices were not on her care plan she knew what to do because most of the residents have the same equipment and she has been trained and used all of the equipment before. She stated the side rails are used for positioning, the belt is to always be on when residents are in their wheelchairs, and the wander guard was so residents could not leave the unit. Upon interview on 4/9/26 at 2:06 p.m. the director of nursing (DON) stated if all the devices are not on the care plan they should be. Upon interview on 4/13/26 at 3:22 p.m. the Administrator stated her expectation that all cares, services, and interventions were on each resident's care plan. A facility policy titled Person-Centered Care Planning dated 1/3/25 indicated: A comprehensive person-centered plan of care will be developed for each client within 7 days after completion of the comprehensive assessment and will include measurable objectives and times to meet a client's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive plan of care will minimally include: • The services that are to be furnished to attain or maintain the client's highest practicable physical, mental, and psychosocial well-being. • Any services recommended by the interdisciplinary team but refused by the client. • The client's goals for admission and desired outcomes. • The client's preference and potential for future discharge. • Discharge plans 1. The comprehensive care plan will be prepared by an interdisciplinary team that includes, but is not limited to: a. The attending provider b. An RN with responsibility for the client	F0657		

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F0657 SS = D	Continued from page 25 c. A resident assistant with responsibility for the client d. A member of food and nutrition services staff e. If practical the client and the client's representative. If not practical, document an explanation why the client or client representative are not part of the development of the plan of care. f. Other appropriate staff or professionals in disciplines as determined by the client's needs or as requested by the client. 2. Review and revise the comprehensive plan of care after each assessment and include both the comprehensive and quarterly review assessments.	F0657		
F0909 SS = D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as a part of the regular maintenance program to identify areas of possible entrapment for 3 of 3 residents (R1, R2, and R3) reviewed for side rails. The facility did not provide any documentation of inspection or entrapment assessments. Findings include: Recommendations for Health Care Providers Using Adult portable Bed Rails dated 2/27/2023 retrieved on 4/13/26 from https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/hospital-beds indicated, when evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care https: Evaluating the dimensional limits of gaps in hospital	F0909		

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F0909 SS = D	Continued from page 26 beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. Bed safety programs may also include plans for the reassessment of hospital bed systems. Reassessment may be appropriate when (1) there is reason to believe that some components are worn (e.g., rails wobble, rails have been damaged, mattresses are softer) and could cause increased spaces within the bed system, (2) when accessories such as mattress overlays or positioning poles are added or removed, or (3) when components of the bed system are changed or replaced (e.g., new bed rails or mattresses). This guidance describes seven zones in the hospital bed system where there is potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. Descriptions of the seven entrapment zones appear on pages 15-21 in this guidance. Summary drawings of entrapment for all the zones appear in Appendix E. The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below. Zone 1: Within the Rail Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support Zone 3: Between the Rail and the Mattress Zone 4: Under the Rail, at the Ends of the Rail Zone 5: Between Split Bed Rails Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board Zone 7: Between the Head or Foot Board and the Mattress End. Health Care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight,	F0909		

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F0909 SS = D	Continued from page 27 movement, bed position, or by using a specialty mattress. The manufacture user-service manual for Baxter Hill-Rom Centrella Medical-Surgical Hospital Bed, undated, indicated Warning-Evaluate patients for entrapment and fall risk according to facility protocol, and/or healthcare provider directives, and monitor patients appropriately. Make sure all side rails are fully latched when in the raised position. Failure to do either of these could cause serious injury or death. Do annual preventive maintenance procedures to make sure the Centrella Smart+ Bed operates as originally designed. The procedures include examinations of these: Overall condition Siderails Controls and motors Battery Backup Brakes and casters Seale system Head angle display Communication system Transport system Transport system batteries Mattress Accessories WARNING: To help prevent serious injury and/or death, obey these warnings: Warning-Evaluate patients for entrapment and fall risk according to facility protocol and monitor patients appropriately. Warning-Make sure that all side rails are fully latched when in the raised position. Warning-Stay clear of pinch points and moving parts during siderail operation. Siderails are intended to be a reminder to the patient of the bed's edges, not a patient-restraining device. When appropriate, Hill-Rom recommends that medical persons determine the correct methods necessary to make sure a patient stays safely in bed. Siderails in the raised position are intended to make	F0909		

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F0909 SS = D	Continued from page 28 the patient aware of the proximity of the edge of the mattress and to assist in patient entry and exit. R1's Physical Device assessment dated 3/11/26 indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability appropriately using the device as applicable. The device did not restrict voluntary freedom of moment or prevent access to any part. His decision made him understand the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried. Upon observation and interview on 4/7/26 at 12:17 p.m. R1 was seated in his room in wheelchair. He had bilateral quarter rails at the top of his bed that were in the upright position. He had bilateral three-quarter length side rails at the bottom of bed that were lowered. R1 stated, he did not know what the side rails were, but they were on the bed he slept in. He then started speaking nonsensical about having to leave for work and repair cars. R1's Physical Device assessment dated 3/11/26 indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability appropriately use the device as applicable. The device did not restrict voluntary freedom of moment or prevent access to any part. His decision made him understand the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried. R1's physical therapy assessments and notes dated 3/11/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R1's occupational therapy assessments and notes dated 3/11/26 – 4/6/26 did not indicate side rails were in use for R1 or any entrapment assessment.	F0909		

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F0909 SS = D	Continued from page 29 R1's admission Minimum Data Set (MDS) dated 3/18/26 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). MDS did not include use of bedside rails. R1's care plan dated 3/23/26 indicated R1 may use half side rails for positioning and safety when in bed. No other documentation related to the use of side rails was indicated. Upon observation and interview on 4/9/26 at 8:55 a.m. R2 was in bed, two nursing assistants were changing her incontinent brief and getting her dressed for the day. R2 had bilateral quarter sized side rails at the head of her bed. She was unable to roll herself in bed, staff assisted her to roll on her right side, and she held on to the side rail with her left hand throughout the cares. R2 was unable to move the right side of her body. R2 was only able to interview by nodding "yes or no" to questions. R2 indicated through nodding that she could not use her right hand, that she could not turn herself in bed and that she used the side rails when staff assisted her. She could not remove the side rails by herself. R2's Physical Device Assessment dated 2/27/26 indicated R2 had quarter size left and right-side rails. She was able to demonstrate the ability to use the device appropriately and they did not restrict her voluntary freedom of movement or prevent access to a body part. Her decision understood the risk and benefits. R1's symptoms were weakness, impaired mobility, hemiplegia, rehab, to facilitate independence. Her diagnoses of CVA and no less restrictive devices were tried. There was no documentation for any entrapment assessments. R2's physical therapy assessments and notes dated 2/27/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment.	F0909		

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F0909 SS = D	Continued from page 30 R2's occupational therapy assessments and notes dated 2/27/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R2's care plan dated 2/27/26 did not indicate the use of side rails. R2's admission MDS dated 3/6/26 indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2's BIMS score was 00 indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent in toileting and transfers. Her pertinent diagnoses were cerebral infarction, aphasia, dysphagia, symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2's MDS did not indicate the use of the side rails. Upon observation and interview on 4/9/26 at 10:25 a.m. R3 was resting on his bed fully dressed. He had bilateral half rails at the head of his bed. He stated he could reposition himself in bed and use the rails. R3's Physical Device Assessment dated 2/2/26 indicated R2 had right and left quarter sized rails on his bed. He was able to demonstrate the ability to use the device appropriately and it did not restrict any voluntary freedom of movement or prevent access to any body part. Client and our decision maker did not say they understood the risk and benefits. R3's symptoms were impaired judgement and hemiplegia. No other alternatives were tried. R3's diagnosis was a CVA, and no less restrictive devices were tried. R3's summary indicated quarter side rails on bed to help with turning and reposition. There was no documentation for any entrapment assessments. R3's physical therapy assessments and notes dated 2/2/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R3's occupational therapy assessments and notes dated 2/2/26 – 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment.	F0909		

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F0909 SS = D	Continued from page 31 R3's care plan dated 2/9/26 did not indicate the use of side rails. R3's admission MDS dated 2/9/26 indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's MDS did not indicate the use of side rails. On 4/9/26 at 10:45 a.m. a request was made to the maintenance engineer for any documentation of assessments or inspections of resident side rails. No documentation was received. On 4/9/26 at 11:22 a.m. a request was made to the administrator for any documentation of assessments or inspections of resident side rails. She stated she would send the information. No information was received. Upon interview on 4/7/26 at 12:41 p.m. registered nurse (RN)-A stated she was unaware of any safety precautions or inspections on the side rails. She stated therapy was in charge of all equipment. She was not certain if R1 used the lower side rails or if they just were not removed from his bed upon his admission. Upon interview on 4/7/26 at 1:48 p.m. the maintenance engineer stated he had not done anything with side rails expecting to fix them when nursing reports they are broken. Upon interview on 4/8/26 at 11:59 a.m. Physical Therapist (PT)-A stated residents who have a brain injury are all admitted with side rails and a lap belt and then when they saw therapy for the first time devices could be adjusted. She stated nursing would complete any assessments for safety such as the zoning in the bed.	F0909		

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F0909 SS = D	Continued from page 32 A facility policy titled Restraints dated 1/23/24 indicated safety devices are used to enable the residents to attain or maintain their highest level of independent functioning and safety. The decision to use these aids and positioning devices is made through resident participation in individual assessment and care planning by the interdisciplinary team. They are used only with resident consent and under physician order and direction. PROCEDURE: 1) The interdisciplinary team conducts an individual assessment/evaluation to determine the need for any positioning/potentially restraining/safety device. A care plan is developed to identify the residents' needs and parameters for use of the device, i.e., bed rails up at night so residents may use it to assist with turning. This care plan is reviewed at least quarterly and updated as needed. 2) Prior to implementing the care plan, the nurse will review the risks and benefits of the use of the device with the residents. The resident, or if unable, the resident representative, signs the informed consent. The policy did not indicate any inspection timing of the devices.	F0909		
F0846 SS = C	Facility Closure CFR(s): 483.70(l) §483.70(l) Facility closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (l) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a facility closure policy and procedure had been developed. This had the potential to affect all residents residing in the building. Findings include: A policy and procedure covering facility closure was requested from the facility, but facility failed to provide such documentation.	F0846		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	**3915 GOLDEN VALLEY ROAD , GOLDEN VALLEY, Minnesota, 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
F0846 SS = C	Continued from page 33 Email correspondence dated 4/7/26 at 8:16 p.m. the Administrator indicated the facility did not have a policy/procedure on facility closure, as the facility had no intent to close.	F0846		