Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 9, 2025

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

RE: CCN: 245519
Cycle Start Date: May 22, 2025

Dear Administrator:

On July 7, 2025, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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July 9, 2025

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

Re: Reinspection Results
Event ID: HI5P12

Dear Administrator:

On July 7, 2025, 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 May 22, 2025. 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
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
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June 9, 2025

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

RE: CCN: 245519
Cycle Start Date: May 22, 2025

Dear Administrator:

On May 22, 2025, a 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 22, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 22, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING _____ B. WING _____	C 05/22/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/20/25 through 5/22/25, 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: H55194908C (MN113107) with a deficiency cited at F686. H55194940C (MN113100) 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.	F 000		
F 686 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	F 686		7/1/25

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

Electronically Signed | 06/19/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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 2 residents (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. Braden Pressure Ulcer Risk Assessment dated 4/17/25 indicated a score of 16, low. (The Braden Scale is a tool used to assess a patient's risk for pressure ulcers, with lower scores indicating higher risk. Scores between 15 and 18 are considered at mild risk). R1's admission Minimum Data Set (MDS) dated 4/24/25, indicated R1 had spinal cord dysfunction, anxiety disorder, no mood, or behavioral issues. The MDS indicated R1 had upper and lower extremity impairment, used a wheelchair, required moderate assist with bed mobility, had a	F 686	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 has discharged from the facility. Any resident could potentially be affected. The standard work procedure for refusal of care will be revised to support communication of resident refusals, resident education about risks and benefits, and revision of the care plan. One of the revisions to the standard work procedure includes adding Behavior Observation to the required charting for nursing assistants each shift for each resident, to facilitate documentation of	

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F 686	Continued From page 2 catheter, was frequently incontinent of bowel and had no pressure ulcers. R1's Care Plan dated 5/06/25, indicated impaired skin integrity or potential for impaired skin integrity related to injury sensation impairment. The care plan directed staff to provide skin checks with am and p.m. routines, take extra care with transfers, treat wound/open areas per physician orders, turn and reposition at night every 3 hours, protective specialty mattress, use turn sheet to avoid friction/shearing, cushion/pressure relieving devices, referral to dietician, referral to physical therapy for positioning seating needs, educate on nutritional needs, educate and encourage participant increasing skin tolerance, give verbal cues to reposition assist as needed, instruct and assist participation in learning methods of prevention of pressure ulcers. R1's Care Plan further indicated R1 experiences a disruption in the amount or quality of sleep, which interferes with their desired lifestyle related to anxiety, care needs, emotional state, unfamiliar surroundings. The care plan directed staff to assess and document sleeping pattern, assist and participate in quiet nighttime environment, help participant identify possible causes of interrupted sleep and what aides sleep, provide comfort measures, refer for complementary care services. R1's Admission Skin Assessment dated 4/17/25, indicated R1 was at risk for pressure ulcer, skin was clear with no impairment. R1's Wound Assessment dated 5/01/25, indicated R1 had hemiplegia (paralysis to one side of the body) an hemiparesis (one sided muscle weakness) following cerebral infraction	F 686	refusal of care. Staff will be educated regarding the regulation and this plan of correction including the revised standard work procedure. 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 7/24/25 QAPI meeting. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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F 686	Continued From page 3 (stroke where blood flow to the brain is blocked) affecting right dominant side. The assessment indicated R1 had a left buttock pressure wound occurred during stay at the facility and was deep tissue pressure injury. The assessment indicated the wound was found by staff during a skin assessment. Assessment indicated resident typically goes to bed at 4:30 p.m. and only gets turned once at night to lay on her left side. The note indicated "this was likely the cause of the pressure injury. However, the wound has linear sides that could have been caused by laying or sitting on an object. Assessment went on to identify resident did not have input on how the pressure ulcer may have occurred, but does not have feeling in this area." The assessment indicated the wound measurements were 7.5 centimeters (cm) x 5 x 0.1. The description indicated deep purple, none blanchable, square shaped with irregular ends. Small areas of open dermis 1 cm x 1.5 x 01 on medial wound edge. R1's Point Click Care (PCC)(electronic medical charting system) record from 4/17/25 through 5/21/25 lacked evidence of repositioning refusals on the overnight shifts. documentation of repositioning R1 remained in the hospital as of 5/22/25 and was unable to be observed or interviewed during survey. During interview on 5/21/25 at 11:05 a.m., nursing assistant (NA)-A stated she normally worked day shift but picked up the evening shift on 5/01/25. She had provided R1 a shower and noticed a reddened area on her buttocks and informed registered nurse (RN)-B. NA-A stated prior to finding the area she was not aware of R1 being	F 686		

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F 686	Continued From page 4 on a repositioning program and new she would not want to be bothered during the night shift due to preferring to sleep and not be woken up on the overnight. During interview on 5/21/25 at 11:35 a.m., nurse practitioner (NP) stated R1 was very particular about her cares, and felt the staff have spent a lot of time encouraging her to reposition and attempting to meet her needs even though she would refuse. The NP further stated he was informed by administration she did not want to be turned much at night. NP indicated he felt the facility was doing what they could and relied on the wound care nurse for direction. He did not believe the new pressure injury could be directly correlated to just the refusals. The NP stated when the pressure injury was found on 5/01/25, it was deep and when it surfaced it was going to look bad. The NP stated R1 was sent to the hospital on 5/13/25, due to fever and possible wound infection. During interview on 5/22/25 at 6:40 a.m., registered nurse (RN)-D stated she was a charge nurse who worked with R1 during the night shift, and it would depend on R1's mood if she would allow the staff to reposition her. RN-D added, NAs always attempted and encouraged her but sometimes she wanted to just keep sleeping. During interview on 5/22/25 at 6:56 a.m., NA-B stated when R1 first admitted she would tell us she did not want to be bothered, and she would put her call light on when she wanted to be repositioned, she was getting repositioned at night but not always every 3 hours. There was no way to document R1's refusals in PCC (if she was repositioned successful at any point that	F 686		

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F 686	Continued From page 5 shift) but the nurses were aware she would refuse. NA-B stated after a wound was found on her bottom, we were then instructed to have her reposition every two to three hours even then she would still refuse, but we would encouraged her. During interview on 5/22/25 at 9:48 a.m., administrator stated R1 was adamant she did not want to be disturbed during the night and would prefer to call for help to reposition at night due to her anxiety and focused need to not have her sleep disrupted. The administrator further indicated R1's record lacked a risk versus benefit related to her refusals to reposition. Additionally, R1's records did not indicate the refusals on the overnight due to how PCC works (can not mark a refusal unless resident refuses all shift), all though it was well known she refused at times. Administrator indicated the care plan did direct staff to provide verbal cues for repositioning as needed but a risk versus benefit discussion and notification to her team/Physician would have been helpful to potential avoid acquiring the pressure sore. During interview 5/22/25 at 10:30 a.m., physical therapist (PT) stated she completed pressure mapping on R1 on 5/03/25 and felt the pressure ulcer likely occurred if she was consistently getting repositioned at night. R1 also spends a lot of time in her wheelchair during the day going to appointment with therapy and activities and can shift her weight independently. We provided her with a new cushion in her wheelchair and a high performance specialty mattress on her bed to better combat the possible refusals. During interview on 5/22/25 at 11:45 a.m., RN-A stated she is the facility's wound care nurse and	F 686		

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F 686	Continued From page 6 was informed of R1's unstageable pressure ulcer on 5/01/25. R1 had informed her she was refusing repositioning on the overnight when she wanted to keep sleeping. RN-A's assessment of the pressure ulcer also left her with an impression R1 could have slept on her cell phone all night or had continuous pressure from an object on her left buttocks. RN-A stated after R1's pressure ulcer was acquired she did agree to be repositioned around 10:00 p.m., 1:00 a.m. and 5:00 a.m. but was not aware of how refusals were being tracked during each shift. RN-A confirmed there was no risk versus benefits completed with R1 when she was refusing, and indicated not being repositioned every three hours could have also contributed to acquiring the pressure ulcer. During interview on 5/22/25, at 12:30 p.m., family member (FM)-A stated she was not informed R1 was refusing to be repositioned during the night and if she had been informed, she would have talked to her about the importance of getting repositioned. In addition, FM-A stated after the pressure ulcer was found she had spoken and emailed the facility related to repositioning and her concerning of not be informed and believing the facility was responsible for R1 acquiring the pressure sore. Allina Health Department MDS and Comprehensive Assessment Process policy effective date 6/01/23, All Minimum Data Set and Care Area Assessments will be completed as required and within the timeframe's identified in the Resident Assessment Instrument Manual. The rehabilitation team uses the information from the MDS assessment and supplementary assessments to develop client-specific care plans. The client, family/support person, and	F 686		

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F 686	Continued From page 7 interdisciplinary team are involved in creating the care plan initially and on an ongoing basis. The facility had no other policies related to pressure ulcers.	F 686		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 9, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: HI5P11

Dear Administrator:

The above facility was surveyed on May 20, 2025 through May 22, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
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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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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Saint Paul, Minnesota 55164-0970
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00751	A. BUILDING: _____ B. WING _____	C 05/22/2025

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/20/25 through 5/22/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H55194908C (MN113100) H55194940C (MN113107) with a licensing order issued at 0900. 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN 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 2 residents (R1) who was identified as refusing repositioning on the overnight and acquired a new pressure sore.	2 900	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	7/1/25

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2 900	Continued From page 3 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. Braden Pressure Ulcer Risk Assessment dated 4/17/25 indicated a score of 16, low. (The Braden Scale is a tool used to assess a patient's risk for pressure ulcers, with lower scores indicating higher risk. Scores between 15 and 18 are considered at mild risk). R1's admission Minimum Data Set (MDS) dated 4/24/25, indicated R1 had spinal cord dysfunction, anxiety disorder, no mood, or behavioral issues. The MDS indicated R1 had upper and lower extremity impairment, used a wheelchair, required moderate assist with bed mobility, had a catheter, was frequently incontinent of bowel and had no pressure ulcers. R1's Care Plan dated 5/06/25, indicated impaired skin integrity or potential for impaired skin integrity related to injury sensation impairment. The care plan directed staff to provide skin checks with am and p.m. routines, take extra care with transfers, treat wound/open areas per physician orders, turn and reposition at night every 3 hours, protective specialty mattress, use turn sheet to avoid friction/shearing, cushion/pressure relieving devices, referral to	2 900	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 has discharged from the facility. Any resident could potentially be affected. The standard work procedure for refusal of care will be revised to support communication of resident refusals, resident education about risks and benefits, and revision of the care plan. One of the revisions to the standard work procedure includes adding Behavior Observation to the required charting for nursing assistants each shift for each resident, to facilitate documentation of refusal of care. Staff will be educated regarding the regulation and this plan of correction including the revised standard work procedure. 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 7/24/25 QAPI meeting.	

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2 900	Continued From page 4 dietician, referral to physical therapy for positioning seating needs, educate on nutritional needs, educate and encourage participant increasing skin tolerance, give verbal cues to reposition assist as needed, instruct and assist participation in learning methods of prevention of pressure ulcers. R1's Care Plan further indicated R1 experiences a disruption in the amount or quality of sleep, which interferes with their desired lifestyle related to anxiety, care needs, emotional state, unfamiliar surroundings. The care plan directed staff to assess and document sleeping pattern, assist and participate in quiet nighttime environment, help participant identify possible causes of interrupted sleep and what aides sleep, provide comfort measures, refer for complementary care services. R1's Admission Skin Assessment dated 4/17/25, indicated R1 was at risk for pressure ulcer, skin was clear with no impairment. R1's Wound Assessment dated 5/01/25, indicated R1 had hemiplegia (paralysis to one side of the body) an hemiparesis (one sided muscle weakness) following cerebral infraction (stroke where blood flow to the brain is blocked) affecting right dominant side. The assessment indicated R1 had a left buttock pressure wound occurred during stay at the facility and was deep tissue pressure injury. The assessment indicated the wound was found by staff during a skin assessment. Assessment indicated resident typically goes to bed at 4:30 p.m. and only gets turned once at night to lay on her left side. The note indicated "this was likely the cause of the pressure injury. However, the wound has linear sides that could have been caused by laying or sitting on an object. Assessment went on to identify resident did not have input on how the	2 900	The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

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2 900	Continued From page 5 pressure ulcer may have occurred, but does not have feeling in this area." The assessment indicated the wound measurements were 7.5 centimeters (cm) x 5 x 0.1. The description indicated deep purple, none blanchable, square shaped with irregular ends. Small areas of open dermis 1 cm x 1.5 x 01 on medial wound edge. R1's Point Click Care (PCC)(electronic medical charting system) record from 4/17/25 through 5/21/25 lacked evidence of repositioning refusals on the overnight shifts. documentation of repositioning R1 remained in the hospital as of 5/22/25 and was unable to be observed or interviewed during survey. During interview on 5/21/25 at 11:05 a.m., nursing assistant (NA)-A stated she normally worked day shift but picked up the evening shift on 5/01/25. She had provided R1 a shower and noticed a reddened area on her buttocks and informed registered nurse (RN)-B. NA-A stated prior to finding the area she was not aware of R1 being on a repositioning program and new she would not want to be bothered during the night shift due to preferring to sleep and not be woken up on the overnight. During interview on 5/21/25 at 11:35 a.m., nurse practitioner (NP) stated R1 was very particular about her cares, and felt the staff have spent a lot of time encouraging her to reposition and attempting to meet her needs even though she would refuse. The NP further stated he was informed by administration she did not want to be turned much at night. NP indicated he felt the facility was doing what they could and relied on the wound care nurse for direction. He did not	2 900		

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2 900	Continued From page 6 believe the new pressure injury could be directly correlated to just the refusals. The NP stated when the pressure injury was found on 5/01/25, it was deep and when it surfaced it was going to look bad. The NP stated R1 was sent to the hospital on 5/13/25, due to fever and possible wound infection. During interview on 5/22/25 at 6:40 a.m., registered nurse (RN)-D stated she was a charge nurse who worked with R1 during the night shift, and it would depend on R1's mood if she would allow the staff to reposition her. RN-D added, NAs always attempted and encouraged her but sometimes she wanted to just keep sleeping. During interview on 5/22/25 at 6:56 a.m., NA-B stated when R1 first admitted she would tell us she did not want to be bothered, and she would put her call light on when she wanted to be repositioned, she was getting repositioned at night but not always every 3 hours. There was no way to document R1's refusals in PCC (if she was repositioned successful at any point that shift) but the nurses were aware she would refuse. NA-B stated after a wound was found on her bottom, we were then instructed to have her reposition every two to three hours even then she would still refuse, but we would encouraged her. During interview on 5/22/25 at 9:48 a.m., administrator stated R1 was adamant she did not want to be disturbed during the night and would prefer to call for help to reposition at night due to her anxiety and focused need to not have her sleep disrupted. The administrator further indicated R1's record lacked a risk versus benefit related to her refusals to reposition. Additionally, R1's records did not indicate the refusals on the overnight due to how PCC works (can not mark a	2 900		

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2 900	Continued From page 7 refusal unless resident refuses all shift), all though it was well known she refused at times. Administrator indicated the care plan did direct staff to provide verbal cues for repositioning as needed but a risk versus benefit discussion and notification to her team/Physician would have been helpful to potential avoid acquiring the pressure sore. During interview 5/22/25 at 10:30 a.m., physical therapist (PT) stated she completed pressure mapping on R1 on 5/03/25 and felt the pressure ulcer likely occurred if she was consistently getting repositioned at night. R1 also spends a lot of time in her wheelchair during the day going to appointment with therapy and activities and can shift her weight independently. We provided her with a new cushion in her wheelchair and a high performance specialty mattress on her bed to better combat the possible refusals. During interview on 5/22/25 at 11:45 a.m., RN-A stated she is the facility's wound care nurse and was informed of R1's unstageable pressure ulcer on 5/01/25. R1 had informed her she was refusing repositioning on the overnight when she wanted to keep sleeping. RN-A's assessment of the pressure ulcer also left her with an impression R1 could have slept on her cell phone all night or had continuous pressure from an object on her left buttocks. RN-A stated after R1's pressure ulcer was acquired she did agree to be repositioned around 10:00 p.m., 1:00 a.m. and 5:00 a.m. but was not aware of how refusals were being tracked during each shift. RN-A confirmed there was no risk versus benefits completed with R1 when she was refusing, and indicated not being repositioned every three hours could have also contributed to acquiring the pressure ulcer.	2 900		

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2 900	Continued From page 8 During interview on 5/22/25, at 12:30 p.m., family member (FM)-A stated she was not informed R1 was refusing to be repositioned during the night and if she had been informed, she would have talked to her about the importance of getting repositioned. In addition, FM-A stated after the pressure ulcer was found she had spoken and emailed the facility related to repositioning and her concerning of not be informed and believing the facility was responsible for R1 acquiring the pressure sore. Allina Health Department MDS and Comprehensive Assessment Process policy effective date 6/01/23, All Minimum Data Set and Care Area Assessments will be completed as required and within the timeframe's identified in the Resident Assessment Instrument Manual. The rehabilitation team uses the information from the MDS assessment and supplementary assessments to develop client-specific care plans. The client, family/support person, and interdisciplinary team are involved in creating the care plan initially and on an ongoing basis. The facility had no other policies related to pressure ulcers. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers, ensure refusal for treatment are tracked and reported and risk versus benefits are provided to appropriate residents who continue to refuse treatment interventions. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have	2 900		

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2 900	Continued From page 9 the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		