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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OTR4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00751

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

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

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

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

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

6. DATE OF SURVEY **01/07/2019** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE: Kathleen Lucas, Unit Supervisor — Date: 01/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL: Alison Helm, Enforcement Specialist — Date: 01/09/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/07/2019** (L33)

DETERMINATION APPROVAL

Electronically delivered
January 7, 2019

Administrator
Courage Kenny Rehabilitation Institute's TRP
3915 Golden Valley Road
Golden Valley, MN 55422

RE: Project Number S5519030

Dear Administrator:

On December 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 16, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 7, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 26, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 16, 2018, effective December 26, 2018 and therefore remedies outlined in our letter to you dated December 4, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
CMS Certification Number (CCN): 245519

January 7, 2019

Administrator
Courage Kenny Rehabilitation Institute's TRP
3915 Golden Valley Road
Golden Valley, MN 55422

Dear Administrator:

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

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

Effective December 26, 2018 the above facility is certified for:

48 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OTR4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00751

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

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

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

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

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

6. DATE OF SURVEY **11/16/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Jody McLeod, HFE NE II 12/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 01/07/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
December 4, 2018

Administrator
Courage Kenny Rehabilitation Institute's TRP
3915 Golden Valley Road
Golden Valley, MN 55422

RE: Project Number S5519030

Dear Administrator:

On November 16, 2018, a standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 26, 2018.

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.

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 a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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 February 16, 2019 (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 May 16, 2019 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

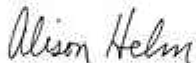
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/13/18 through 11/16/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On Nov, 13 through Nov, 16th 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		12/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/12/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure the physician was notified of an increase in weight for 1 of 3 residents (R46) who had specific physician's orders with parameters for physician notification. Findings include: R46's Admission Record dated 11/16/18, indicated R46's diagnoses traumatic brain injury (TBI), dependence on renal dialysis and end stage renal disease (ESRD). R46's admission Minimal Data Set (MDS) dated 10/29/18, indicated R46 was cognitively intact. R46's physician orders dated 10/22/18, included order for daily weights in morning with instruction to call medical doctor if weight increases 2 pounds in 24 hours or 5 pounds in 7 days. R46's care plan dated 11/11/19 indicated intervention of daily weight in morning, call medical doctor (MD) if increases by 2 pounds in 24 hours or 5 pounds in 7 days. Review of R46's weights from 10/23/18 - 11/16/18: -11/2/18 weight 126.2 (standing) -11/3/18 weight 130.0 (standing) 3.8 pound increase. The medical record lacked evidence of notification to the physician with an increase of greater than 2 pounds in 24 hours. -11/4/18 weight 131.0 (standing)	F 580	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. F580 Notification of Changes Courage Kenny Rehabilitation Institute□s TRP immediately informs the resident, consults with the resident□s physician, and notifies, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident□s physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.1(c)(1)(ii). R46 has discharged from the facility. The facility has identified all current clients with weight orders more specific than the standing order for weekly weights. The policy and procedure concerning weights has been reviewed and revised. Staff will be inserviced regarding notification requirements as well as the policy and procedure. The Administrator or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 -11/5/18 weight 134.0 (standing) 3.0 pound increase. The medical record lacked evidence of notification to the physician with an increase of greater than 2 pounds in 24 hours. -11/11/18 weight 127.4 (standing) -11/12/18 weight 131.0 (standing) 3.6 pound increase. The medical record lacked evidence of notification to the physician with an increase of greater than 2 pounds in 24 hours. When interviewed on 11/15/18, at 11:13 a.m. registered nurse (RN)-C stated if there is a 2 pound increase we notify the doctor. RN-C went on to say, it should be charted in nursing progress notes, sometimes it doesn't if we get too busy. When interviewed on 11/16/18, at 10:20 a.m. nurse practitioner (NP)-C stated he was not informed of any weight increases. NP-C stated nursing should notify him if more than 2 pound increase in 24 hours. On 11/16/18, at 11:04 a.m. director of nursing (DON) stated the nurse working should call and talk to medical provider if it is the weekend, during the week NP-C should be contacted in person. Typically if they call or talk to the provider it is good practice to make a progress note. Facility policy, Notification of Change in Client Status dated 10/18, indicated when a change in status occurs, the nurse notifies the provider. All notifications will be documented in the medical record.	F 580	complete random weekly audits to ensure that providers are notified of actionable weight changes until the next QAPI meeting, 1/3/19. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 4	F 655		

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 5 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a copy of the baseline care plan was provided to the resident and/or representative for 1 of 12 residents (R5) reviewed who was a new admission. Findings include: R5's Admission Record indicated R5 was admitted to the facility on 8/7/18. R5's admission Minimum Data Set (MDS) dated 8/14/18, indicated a care plan completion decision date of 8/19/18. R5's Program Review dated 8/21/18, indicated what R5's rehabilitation goals were from physical therapy, occupational therapy, and speech therapy. The Program Review also included information from a medical and medication perspective and social worker perspective on discharge. However, the Program Review lacked indication that R5 was offered or had received a copy of the base line care plan. During an interview on 11/16/18, at 8:23 a.m. R5 was asked if R5 received a written summary of the base line care plan. R5 stated a copy of the program review (base line care plan) was not provided. During an interview on 11/15/18, at 1:04 p.m. the social worker (SW)-A stated SW-A handed the	F 655	F655 Baseline Care Plan Courage Kenny Rehabilitation Institute□s TRP develops and implements a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. R5 has been provided a summary of his care plan. All current residents have been provided summaries of their care plans. The care plan policy and procedure has been reviewed and revised. Staff will be inserviced regarding the regulation as well as the policy and procedure. The Administrator or designee will complete random weekly audits of new admissions to ensure that residents receive copies of their baseline care plans until the next QAPI meeting, 1/3/19. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 6 residents a copy of the program review. SW-A stated they verbally tell the residents they get a copy of the program review. SW-A stated there is no documentation that R5 was provided with a copy of the base line care plan on 8/21/18. A policy related to baseline care plans was requested and not provided.	F 655		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure weights were consistently monitored for 1 of 1 residents (R48) reviewed for closed record hospitalization and who had a significant weight increase and a diagnosis of congestive heart failure. Findings include: A 6/7/18 Admission Nursing Assessment included a diagnosis of heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues). An admission Minimum Data Set (MDS), dated 6/14/18, indicated R48 was cognitively intact. R48	F 684	F684 Quality of Care Courage Kenny Rehabilitation Institute□s TRP ensures that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident□s choices. R48 has discharged from the facility. The facility has identified all current clients with weight orders more specific than the standing order for weekly weights. The policy and procedure concerning weights has been reviewed and revised. Staff will be inserviced regarding the regulation as well as the policy and procedure.	12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7 required extensive assistance with bed mobility and total dependence with transfers. R48's care plan, last reviewed 9/26/18, lacked identification of congestive heart failure and interventions for weights. R48's June 2018 Treatment Administration Record (TAR) indicated weight twice weekly every day shift on Sundays and Wednesdays for congestive heart failure. -6/13/18 (Wednesday) weight 255.1 pounds. -6/17/18 (Sunday) weight 248.5 pounds. -6/20/18 (Wednesday) weight 256 pounds. -6/24/18 (Sunday) weight 257 pounds. -6/27/18 (Wednesday) weight 258 pounds. R48's July 2018 Treatment Administration Record indicated weight twice weekly every day shift on Sundays and Wednesdays for congestive heart failure. -7/1/18 (Sunday) weight 250 pounds. -7/4/18 (Wednesday) weight 249.4 pounds. -The TAR lacked weight documentation for 7/8/18, 7/11/18 R48's medical record lacked a weight between 7/4/18 and 7/10/18. A Weights and Vitals Summary identified a weight on 7/11/18 of 270 pounds, an increase of 20.6 pounds from 7/4/18 weight. A progress note, dated 7/11/18 identified the 20 pound weight gain. The note indicated lung sounds clear. Edema (swelling) present both legs, but no greater than baseline. Communicated to evening shift to get weight when in bed. R48's record lacked a follow up	F 684	The Administrator or designee will complete random weekly audits to ensure that weights are monitored appropriately until the next QAPI meeting, 1/3/19. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8	F 684		

weight on 7/11/18.

A visit note by Physician (D) on 7/12/18, identified a significant weight increase on routine measurement. R48 has not felt differently and feels he has gained some weight over time and is trying to eat less. Denies chest pain or shortness of breath. Lungs clear. No exam findings to support volume overload, although he is at risk.

R48's medical record identified the next documented weight on 7/17/18, 1 week after the 20 pound weight gain. The record had inconsistencies documented with the Weights and Vials Summary identifying a weight of 272.4 pounds 7/17/18. The Weights and Vials Summary on 7/18/18 identified a weight of 269.9 pounds; however, the July 2018 TAR identified a weight of 272.4 pounds on 7/18/18.

R48's medical record lacked weights between 7/19/18 to 7/24/18.

A 7/24/18 progress notes indicated R48 had complaints of anxiety and shortness of breath. Blood pressure was increased at 176/108 with a recheck of 157/109. Nurse practitioner was notified. Nurse practitioner requested to administer Ativan (antianxiety medication) x 2. R48 had no relief. Left sided chest pain reported. Sent to hospital.

Hospital discharge orders on 7/27/18 identified R48 was hospitalized with congestive heart failure.

The Weights and Vitals Summary identified a weight of 252 pounds on 7/28/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9 During an interview on 11/15/18, at 12:42 p.m. registered nurse (RN)-A stated the nursing assistants obtain weights and the nurse checks the weight for variances. RN-A stated the weights are documented by the nurse and documented on the TAR and reviewed for changes. RN-A stated if the TAR is blank it "got missed." During an interview on 11/16/18, at 10:49 a.m., the director of nursing (DON) stated the provider orders weights which are tracked by documentation on the TAR. The DON reviewed R48's TAR and stated weights were missing. The DON stated R48 was to be weighed twice weekly. CHF and monitoring of weights are to be identified in the care plan. The DON reviewed R48's care plan and stated she was unable to locate problem of CHF or interventions on the care plan. The policy related to monitoring weights was requested and not provided.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 10 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure medications were available, and administered as prescribed by the physician, for 2 of 2 residents (R24, R28) whom did not have medications available at prescribed administration times. Findings include: R24's quarterly Minimum Data Sets (MDS), dated 10/6/18, included diagnoses of anemia, (low iron in blood) aphasia, (unable to communicate) cerebrovascular accident (stroke) and hemiplegia, (paralysis on one side of body). The MDS indicated R24 had severe cognition impairment. R24's Physician Order Sheet dated 11/16/18, indicated R24 had an order for coumadin (blood	F 755	F755 Pharmacy Courage Kenny Rehabilitation Institute□s TRP provides routine and emergency drugs and biologicals to its residents. The warfarin administration times for R24 and R28 have been adjusted. The administration times have been adjusted for all current residents receiving warfarin. The policy and procedure regarding medication administration will be reviewed and revised as appropriate. Staff will be inserviced regarding the regulation as well as the revised policy and procedure. The Administrator or designee will complete random weekly audits to ensure timely administration of warfarin until the next QAPI meeting, 1/3/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 11 thinner) 7.5 mg by mouth one time a day. The Medication Administration Record, (MAR) indicated coumadin was scheduled to be given at 5:00 p.m. daily. The Physician Order Sheet also included an order for an international normalized ratio (INR), (blood test to determine how well the blood thinning medication is working) was ordered to determine coumadin dose. R24's Medication Admin Audit Report dated 10/1/18 through 11/16/18 indicated R24's coumadin was administered late (more than one hour after scheduled administration time of 5:00 p.m.) on several occasions. Time and dates administered late included: 10/1/18- 8:17 p.m., 10/3/18- 9:19 p.m., 10/8/18- 8:27 p.m., 10/30/18- 8:43 p.m., 11/1/18- 9:05 p.m., 11/2/18- 8:29 p.m., 11/7/18- 8:49 p.m., 11/9/18- 9:21 p.m., and 11/14/18- 8:09 p. m. R28's admission MDS dated 10/10/18, included diagnoses of hypertension, (elevated blood pressure) CVA, aphasia, hemiplegia and depression. The MDS indicated R28 had severe cognitive impairment. R28's Physican Order Sheet dated 11/16/18, indicated R28 had an order for coumadin 9 mg, by mouth one time a day. Time for coumadin to be administered in the MAR was 5:00 p.m. daily. An order for INR was ordered to determine correct dose. R28's Medication Admin Audit Report dated 10/1/18 through 11/16/18, indicates R28's coumadin was administered late (more than one hour after scheduled administration time of 5:00 p.m.) Times and dates administered late	F 755	The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 12 included: 10/10/18- 12:48 a.m. (due on 10/9/18), 10/15/18- 8:18 p.m., 10/17/19- 8:18 p.m., 10/19/18- 8:20 p.m., 10/24/18- 9:16 p.m., 10/16/18- 8:19 p.m., 10/27/18 7:40 p.m., 10/28/18- 9:09 p.m., 11/2/18- 8:40 p.m., 11/7/18- 8:21 p.m., 11/9/18- 9:14 p.m., 11/12/18- 8:34 p.m., and 11/14/18- 8:03 p.m. During an interview on 11/14/18, at 4:19 p.m. registered nurse (RN)-B stated R24's coumadin scheduled for 5:00 p.m. was not in the facility. RN-B stated it needs to come from pharmacy based on the INR results for the day. RN-B stated this happens regularly on days the lab draws blood from patients scheduled for an INR. RN-B stated the pharmacy does not deliver the coumadin until evening around 8:00 p.m. During an interview on 11/14/18, at 4:45 p.m. licensed practical nurse (LPN)-A stated she had seen coumadin given after the scheduled administration time of 5:00 p.m. LPN-A stated the facility does not have an in house pharmacy or lab, so it was typical for coumadin to be given late after 8:00 p.m. on days when INR are done. During an interview on 11/14/18, the director of nursing (DON) stated coumadin is delivered to the facility daily on lab draw days as the INR results may affect the dose of coumadin to be administered. The DON stated the coumadin can not be given until delivered by pharmacy which may be after 8:00 p.m. The DON stated the facility quality improvement committee identified a need to look at coumadin and the INR process as it was a concern the nursing staff was having. The DON stated the nursing concern was giving coumadin much later then the scheduled	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 13 administration time. A medication administration policy was requested but not received.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 5 residents (R98) reviewed for unnecessary medications was free of significant medication errors when an order for Xarelto (an anticoagulant, used to treat blood clots in the lungs or in the veins) was not transcribed correctly in the electronic medical record according to physician's orders resulting in the resident receiving the medication when it was not to be given. Findings include: R98's Diagnosis Report dated 11/16/18 was reviewed. R98's diagnoses included hemiplegia and hemiparesis, cerebral infarction affecting right side, atrial fibrillation and hypertension. When interviewed on 11/13/18, at 11:09 a.m. R98 stated he had to go back into the hospital because they screwed up my blood thinners. R98's physician order dated October 24, 2018, indicated, continue Lovenox (is an anticoagulant that helps prevent the formation of blood clots) 120 mg/0.8 milliter (ML) injection 0.7 ML	F 760	F760 Significant Med Errors Courage Kenny Rehabilitation Institute□s TRP ensures that its residents are free of any significant medication errors. The medication error for R98□s xarelto has been investigated and follow-up completed with the staff involved. For all current residents receiving anticoagulation therapy, the anticoagulation orders will be reviewed for accurate transcription. Any identified errors will be remedied, investigated, and follow-up will be completed with the staff involved. Policies and procedures related to transcription of medication orders will be reviewed and revised as appropriate. Staff will be inserviced regarding the regulation as well as the policy and procedure. The Administrator or designee will complete random weekly audits to ensure accurate transcription of medication orders until the next QAPI meeting, 1/3/19. The Administrator will share audit results	12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 14	F 760		

subcutaneous every 12 hours for 8 days ending 10/31/18. Give Xarelto 20 milligrams (mg) daily with dinner starting 11/1/18.

R98's October 2018 medication administration record (MAR) indicated give Xarelto 20 mg by mouth one time a day for atrial fibrillation with a start date of 10/24/18.

R98's October 2018 MAR indicated R98 received Xarelto 20 mg on October 24th and 25th 2018 at 5 p.m. with a discontinue date of 10/25/18 at 5:40 p.m.

R98's Chronological Record of Medication Regimen Review dated 10/28/18 by consulting pharmacist (CP), indicated R98 received 2 doses of Xarelto, one on 10/24/18 and one on 10/25/18, however, the medication was not ordered to start until 11/1/18.

R98's progress notes dated 10/26/18, indicated R98 started having right leg pain. Ice packs were implemented, pain continued and an ultrasound was ordered on 10/29/18 to rule out a deep vein thrombosis (DVT)(blood clot). R98 was sent to the emergency room, and was admitted for further testing. His admitting diagnosis was hematoma (bruise) of right leg. The progress nots indicated R98 returned to the facility on 11/05/18.

When interviewed on 11/15/18, at 8:19 a.m. director of nursing (DON) stated, there should have been a medication error form completed. The DON stated she didn't see any follow up, or know how the Xarelto got discontinued.

When interviewed on 11/15/18, at 8:44 a.m.

Provider's plan of correction (F 760):

with the QAPI committee for further recommendations.
The Administrator is responsible for compliance with this requirement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 15	F 760		

health unit coordinator (HUC) stated, the orders are faxed to nursing station, then faxed to West Health Pharmacy. The HUC stated she will then transcribe the orders and then a second check is performed by the nurse. HUC stated she didn't know anything about an error with the Xarelto order.

When interviewed on 11/15/18, at 11:30 a.m. CP stated she had noticed the error during the medication review, and saw it had been dealt with. CP went on to say the medication should have been out of R98's system and could not say if this could have led to his hospitalization for the hematoma.

When interviewed on 11/15/18, at 3:55 p.m. registered nurse (RN)-D stated she had not recognized a medication error with the Xarelto. RN-D stated she gave the Xarelto on 10/25/18 at 5:00 p.m. RN-D went on to say, she did transcribe the discontinue order for the Xarelto later on in her shift that was left by the nurse practitioner (NP), the order indicated wrong transcription. RN-D stated if a medication error is discovered, we are trained to assess the resident, then call the medical doctor and follow their orders and document in the resident's progress notes and complete a medication error form.

When interviewed on 11/16/18, at 10:14 a.m. NP stated, he did note the transcription error when reviewing orders from the hospital, the Xarelto should have started on November 1st. NP went on to say, he usually fills out a medication error report when errors are discovered, but this time he didn't. NP stated he did not talk to the nurses regarding the transcription error. NP went on to say he only had knowledge of R98 receiving the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 16 Xarelto only once, he did not know R98 received the Xarelto the second time. NP stated he wrote the order to discontinue the Xarelto around 3:00 p.m. on 10/25/18. NP went on to say he thought R98's Xarelto was scheduled for bedtime and the discontinue order would have been transcribed by then. NP stated when he writes an order he flags the chart and put it on the HUC's desk. NP stated he could not say if this could have contributed to his hospitalization for the hematoma. The Adverse Drug Event, Medication Error and Adverse Drug Reaction Notification Reporting, and Review Procedures dated 6/2018, indicated the provider/RN/pharmacist evaluate, take action when appropriate in response to adverse drug event, medication error, or adverse drug reaction. The Transcription Of Physician Orders policy dated 11/4 directed orders must be transcribed immediately after written or received.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 17 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow food safety guidelines to ensure bread was not touched with bare hands during the process of making toast. This practice had the potential to affect 42 out of 43 residents who eat at the facility. Findings include: During observations on 11/13/18, at 7:14 a.m. food service worker (FSW)-A had 4 pieces of bread in the toaster. FSW-A removed the toast with her bare hand and placed the toast on a plate. FSW-A, with bare hands, held onto the toast while buttering. FSW-A picked up the buttered toast with bare hands and transferred the toast onto another plate. FSW-A added 2 eggs to the plate using a spatula and brought the plate to the serving area. -The food service supervisor (FSS), washed her hands. FSS removed 2 pieces of bread from a bread bag. The 2 pieces of bread were wrapped together in plastic bag. FSS placed the bread in the toaster holding onto the plastic bag. FFS did not touch the bread with her bare hands. FSS walked away from the toaster. -FSW-A washed her hands. FSW-A and removed the toast from the toaster with bare hands, placing the toast on a plate. FSW-A held onto the toast with bare hands while buttering the toast.	F 812	F812 Food Sanitation Courage Kenny Rehabilitation Institute□s TRP stores, prepares, distributes, and serves food in accordance with professional standards for food service safety. FSW-A has been re-educated regarding glove use. All current residents have the potential to be affected by this practice. The Food Service policy and procedure regarding hand washing and glove use has been reviewed and revised. Staff will be inserviced regarding the regulation as well as the policy and procedure. The Administrator or designee will complete random weekly audits to ensure appropriate glove use when handling food until the next QAPI meeting, 1/3/19. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 18 FSW-A picked up the toast with bare hands and transferred the toast to another plate. FSW-A washed her hands and brought the plate to the serving area. During an interview on 11/13/18, at 7:47 a.m. FSS stated staff do touch the bread with bare hands in the process of making toast. FSS stated "I am not big on toaster and gloves." adding staff wash their hands a lot during the toasting process. The facility's policy Hand Washing & Glove use, dated 11/1/2011, indicated "Glove Use: Single-use gloves are to be used to create a barrier between food handler's hands and food. All food handlers should use single-use gloves whenever coming into contact with food, no bare hands should come in contact with food. Food service workers hands should be washed between putting on new pair of gloves.	F 812		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility failed to ensure resident's tube feeding pole was clean and sanitary for 1 of 1 residents (R20) reviewed for environment. Findings include: R20's annual Minimum Data Sets (MDS) dated	F 921	F921 Safe/Functional/Sanitary/Comfortable Environment Courage Kenny Rehabilitation Institute□s TRP provides a safe, functional, sanitary, and comfortable environment for residents, staff and the public. R20 has discharged from the facility. The facility has identified all current clients	12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 19 9/6/18, indicated R20 was cognitively intact, with diagnosis of cancer, hypertension, and quadriplegia(paralysis of all 4 limbs). R20 required a gastrostomy (surgical opening into the stomach) feeding tube for more than 51 percent or more of total calories for nutrition daily. R20's physican's orders for Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 10/1/18, through 11/13/18, indicated feedings, medications and fluids were administered through a gastrostomy feeding tube at a minimum of four times daily. During initial observation on 11/13/18, in R20's room, the feeding tube pole was noted to have dried, caked on build up of a cream colored substance all over the medal pole. The cream colored substance intermittently covered the top of pole to the bottom base of the pole and the feeding pump itself had cream colored substance on it as well. During observation on 11/14/18, at 3:58 p.m., in R20's room, R20's feeding tube pole and the feeding tube pump were noted to have a dried, caked on build up of a cream colored substance all over the metal pole from top to bottom, all around the base of the pole, and all over the feeding pump its self. During interview on 11/14/18, at 4:15 p.m. registered nurse (RN)-A stated the feeding tube pole and feeding tube pump looked over due to be cleaned and took the feeding tube pole and feeding tube machine out of R20's room. RN-A stated she would have expected this feeding tube pole to have been cleaned based on the condition	F 921	with IVs and tube feedings. Their IV poles have been cleaned or replaced. The policy and procedure relating to equipment cleaning will be reviewed and revised as needed. Staff will be inserviced regarding the regulation as well as the policy and procedure. The Administrator or designee will complete random weekly audits to ensure IV poles are clean until the next QAPI meeting, 1/3/19. The Administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	11/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 20 it was in. RN-A was not able to state when the feeding tube pole had last been cleaned or who was responsible for cleaning it. During interview on 11/14/18, at 5:37 p.m., the director of nursing (DON) stated equipment should be cleaned and wiped down when visibly soiled or changed out for clean equipment. The DON stated there is no process for cleaning equipment when being used by the same client/resident during a stay at the facility. The DON stated there is a process used after a client/resident is discharged from the facility, and stated the equipment is then brought to a storage unit where a tag is put on the equipment to be cleaned by house keeping. A facility policy was obtained for infection control and reducing the transmission of organisms. The intravascular stands and poles were to be cleaned at discharge with disinfectant by starting at the top of stand/pole and clean down to bottom wiping all surfaces and allow to air dry.	F 921		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/14/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 14, 2018. At the time of this survey, Courage Kenny Rehab Inst Trp was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Courage Kenny Rehab Inst Trp is located on the 1st and 2nd floors of a 3-story building with no basement that was built in 1976 and determined to be of Type II(111) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. This facility is separated from an adjacent business occupancy by 2-hour fire rated construction. The facility has a capacity of 48 beds and had a census of 44 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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