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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE], 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 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. (continued on next page)

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

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's admission Skin assessment dated [DATE], indicated R1 was at risk for pressure ulcer, skin was clear with no impairment. R1's Wound assessment dated [DATE], 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 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 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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.