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	12/10/2025

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. (continued on next page)

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.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 1 resident (R1) who was identified as refusing repositioning on the overnight and acquired a new pressure sore. Findings Include:Definitions of pressure ulcer types according to National Pressure Ulcer Advisory Panel (NPUAP):Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed.R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated diagnoses of traumatic spinal cord dysfunction, neurogenic bladder (condition where nerve damage from the brain, spinal cord, or peripheral nerves leads to a loss of bladder control) and quadriplegia (paralysis that affects all of a person's limbs and body from the neck down). The MDS indicated R1 was cognitively intact and required extensive assistance of two with all activities of daily living. The MDS indicated R1 was at risk for developing pressure ulcers, no pressure ulcers and had pressure reducing device for his chair and bed.R1's Care Plan dated 10/27/25, indicated impaired skin integrity or potential for impaired skin integrity related to immobility. R1's Care Plan goal was to demonstrate a knowledge of risk factors and interventions for preventing skin breakdown with a revision date of 11/03/25. Interventions included assess condition of skin and document weekly, assist in keeping skin clean and dry, cleanse perineal area well with each incontinence, educate and encourage in the importance of meeting nutrition and hydration needs, educate and encourage participant in increasing skin tolerance. If resident refuses repositioning, provide education and document refusal and education provided (initiated 10/27/25). Replace on regular repositioning schedule (initiated 10/15/25), refer to physical therapy (PT) for positioning/seating/mobility needs (initiated 10/15/25), turn and reposition every two hours (initiated 10/15/25). The Care Plan further indicated R1 had indwelling foley catheter and received a new leg bag every morning and new bed bag at night with staff to empty every four hours. R1's Treatment Administration Record (TAR) indicated on 10/26/25, to apply Mepilex (foam dressing) to sacrum (triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis and bilateral gluteal cleft) remove before showers and allow regular skin care. Cleanse with wound cleanser. Cover with large Mepilex. Change daily and as needed for dislodgement every evening shift. The TAR further directed staff to turn and reposition every 2-3 hours with a start date of 10/15/25. Progress Note dated 11/06/25, completed by register nurse (RN)-A indicated a pressure injury staged at Deep Tissue Pressure Ulcer/Injury: Persistent non-blanchable deep red, maroon or purple discoloration. The note indicated Wound history/plan: per client nursing had noted a red area on his coccyx last week. Floor nurse reported this to wound team on Friday 10/24/25, but was unable to be assessed as client was already up and in therapy for the day. Wound was seen over the weekend by nursing and WOC (registered nurse specializing in Wound, Ostomy, and Continence care) first thing on Monday. The note indicted R1 reports he occasionally declined repositioning at night. However, last Wednesday 10/22/25, R1 reports he spend all day in bed due to being sick. Referred to therapy for pressure mapping in bed and chair. The note indicated Wound Status Initial Assessment was on 10/27/25, coccyx 5 centimeters (cm) x1 cm x 0.1 cm and the left buttock 1.5 cm x 0 cm x 0 cm. right gluteal fold developed during stay on 10/24/25. Etiology: wound developed during stay and is from trauma possibly related to sling. Comments indicated as the coccyx wound is a deep tissue injury (DTI) it is impossible to know the extent of the injury before it surfaces and evolves. The coccyx is likely to evolve to a full thickness wound even with strict offloading. Education was provided to R1 about DTPI and the projected evolution. A photo was taken for R1 on his personal cell phone for his own records and education. During interview on 11/05/25 at 1:07 p.m., R1 stated he never had any skin issues at the two previous places he was at for the past 60 days and then arrived at this facility and within 11 days developed a pressure ulcer. R1 stated he did refuse his first or second night to be repositioned due to the night shift staff being so loud with his roommate when providing cares and he was so tired and did not want to be bothered. R1 stated he also got upset with one of the night NAR's when she was attempting to take his shirt off and felt she hurt him and requested for her to never come back in his room. R1 stated now all of the aides are saying he is refusing cares and staff which he feels is not true. R1 stated he recalled on 10/22/25, he was not feeling well and went to bed around 3:00 p.m. and slept until 11:00 a.m. the following day and does not recall any staff