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	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	3915 Golden Valley Road Golden Valley, 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide respect and dignified treatment for 1 of 3 residents (R3) reviewed for dignity. R3 was given a bed alarm that R3 stated he did not consent to. The alarm limited his freedom of movement when he was in bed due to feeling startled by the loud sound of the alarm. In addition, he was anxious because he was concerned his alarm would bother residents near his room.Findings include: The facilities Consent Form for Restraints dated 2/2/26 indicated R3 signed giving consent for the medication trazodone and side rails on his bed. The bed alarm was not on the consent form. R3's admission minimum data set (MDS) dated [DATE] indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3 had mentioned his concerns to the staff. R3's care plan dated 2/4/26 indicated R3 had a bed alarm. The care plan did not indicate how often the alarm was to be used or the placement of the alarm under his body. Upon observation and interview on 4/9/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the lap belt alarm on his wheelchair and the alarm on his wheelchair when he left the unit (wander guard), but he was bothered by the bed alarm. He stated he did not consent to having the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. Upon interview on 4/9/26 at 11:05 a.m. the Nurse Practitioner stated he was aware that R3 had complained about his bed alarm and stated the staff reassured him the alarm was there for his safety and R3 was very cognitively impaired, so staff had to remind him often about his safety needs. Upon interview on 4/9/26 at 1:04 p.m. registered nurse, (RN)-B the nurse manager stated she was not aware that R3 had complaints with his bed alarm, she stated she would fix it immediately by having staff place the alarm up higher on his back, so he can move his legs easier while in bed and the alarm should not sound then unless he stood up. Upon interview on 4/9/26 at 2:06 p.m. the director of nursing, (DON) stated she had not heard of R3's allegations, however when the alarm stops when a resident stops moving their legs. Upon interview on 4/9/26 at 2:33 p.m. R3's Medical Provider stated he had not heard of R3's bed alarm complaint and was not certain how the staff should proceed as safety was the main concern. He thought the staff approach could be modified. Upon interview on 4/13/26 at 9:55 a.m. the Medical Director stated if R3 was having concerns with the bed alarm the facility should try an alternative and the facility should be addressing the concerns stating there is a need to keep him safe, catch him when we think he is getting out of bed, and respect his right to move. A facility policy titled Resident rights dated 9/30/25 indicated Planning and Implementing Care - The facility will:-Permit the resident/resident representative to participate in the development, revision, and implementation of a person-centered plan of care. This includes the right to identify individuals or roles to be included in the planning process, the right to (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	participate in establishing the expected goals and outcomes of care, the right to sign the plan of care, and the right to be informed (in advance) of changes to the plan of care.Inform the resident/resident representative of the right to participate in their treatment and provide support to the resident/resident representative in doing so. This should include information concerning the care to be furnished and the type of caregiver/professional to render services.-Ensure that the physician/practitioner or other professional has informed the resident in advance of the risks/benefits of proposed care, treatment and treatment alternatives/options and the right to choose same.Recognize the resident's right to request/refuse/discontinue treatment, to participate/refuse participation in experimental research, and to formulate an advance directive.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and document review, the facility failed to implement a process to assess for, determine medical symptoms, obtain an order prior to use, assess for use of the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints for 3 of 3 residents (R1, R2, R3) reviewed for use of physical restraints.Findings include: Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 Section P: Restraints and Alarms indicated physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident. Physical restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers. Upon observation and interview on 4/7/26 at 12:17 p.m., R1 was observed to have bilateral quarter side rails at the head of his bed and three-quarter length side rails at the foot of his bed. R1 was seated in his wheelchair with an alarmed seat belt around his waist. On the back of his chair, he had a wander guard bracelet attached to his wheelchair. R1 was not certain what the side rails on his bed were for. He stated that the bed was the bed he slept in. He could not take the lap belt off by himself. He then started speaking incoherently about working in his car in his shop. R1's Physical Device assessment dated [DATE], indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability to appropriately use the device. The device did not restrict voluntary freedom of moment or prevent access to any body part. He understood the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had a brief inventory of mental status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). R1's care plan dated 3/23/26, indicated R1 may use half side rails for positioning and safety when in bed. R1. The side rails were to be used when he was in bed to allow for safe positioning due to spasms. His care plan did not indicate there were side rails attached to the foot of his bed or any interventions for those. R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. The care plan did not indicate when the staff was to release the belt to give R1 freedom of movement. R1 had a wander guard (an electronic security system that uses a bracelet on a resident that alarms when the resident tries to wander outside the facility) that was not identified on the care plan or any interventions for use. Upon (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on 4/8/26 at 8:55 a.m., R2 was in bed, she had bilateral quarter side rails at the head of her bed. She had a seat belt alarm in her wheelchair and a wander guard bracelet attached to the back of her wheelchair. When she was dressed and moved to her wheelchair, she was unable to move her right arm and was unable to remove the lap belt on her own. R2 could not speak, she would nod yes and no to questions. R2?s Physical Device assessment dated [DATE], indicated R2 had quarter size left and right-side rails. She was able to demonstrate the ability to use the device appropriately and they did not restrict her voluntary freedom of movement or prevent access to a body part. Her decision maker understood the risk and benefits. R2's symptoms were weakness, impaired mobility, hemiplegia, rehab, to facilitate independence. Her diagnoses of CVA and no less restrictive devices were tried. R2's admission MDS dated [DATE] indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2's BIMS score was 00 which indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent on toileting and transfers. Her pertinent diagnoses were cerebral infarction (stroke), aphasia (impairment caused by brain damage that impairs a person's ability to process language, speak, read, write, and understand speech), dysphagia (difficulty swallowing), symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2's care plan dated 2/27/26 did not indicate R2 had bilateral quarter sized side rails, the seat belt alarm, or the wander guard. Upon observation and interview on 4/8/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the alarm belt on his wheelchair and the alarm on his wheelchair when he left the unit, but he was bothered by the bed alarm. He stated he did not consent to put the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. R3's Physical Device assessment dated [DATE] indicated R3 had right and left quarter sized rails on his bed. He was able to demonstrate the ability to use the device appropriately and it did not restrict any voluntary freedom of movement or prevent access to any body part. Client and decision maker did not say they understood the risk and benefits. R3's symptoms were impaired judgement and hemiplegia. R3's diagnosis was a CVA, and no less restrictive devices were tried. R3's summary indicated quarter side rails on bed to help with turning and reposition. R3's admission MDS dated [DATE], indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's care plan dated 2/4/26 indicated R3 had a bed alarm, seat belt alarm to be on when in his wheelchair to aide in trunk support, grab bars/bedrails. Email correspondence following the survey on 4/15/26 from the Administrator revealed a facility in-house email chain indicated RN-F interviewed R1, R2 and R3 on 4/10/26 at 3:53 p.m. see below:R3- says he likes and uses the bedrail, able to take off his seatbelt, thinks the seat belt is a good idea, doesn't like the bed or seatbelt alarms because there are too many false alarms, he would be ok with them if they only alarmed when he actually needed them to, but they alarm when he just raises his leg.R1 - says he likes and uses the bedrails, was unable to take off his seatbelt for me, even with prompting, says he hates the seatbelt and the seatbelt alarm and bed alarm.R2 - nodded yes that she likes and uses the bed rails, was able to take off her seatbelt when I asked her to show me, nodded yes that she likes the seat belt, and the bed and the seatbelt alarms. Email correspondence dated 4/11/26 from the Administrator to PT-A indicated R1, R2 and R3 all used the bedrails for either repositioning or transferring. The facility was going to find R1 a different type of belt that R1 could remove. R1 was still on a 1:1 (one staff with a resident all the time) therefore an alarm was not necessary. Email correspondence dated 4/12/26 email from PT-A to the administrator (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated she attempted to see R1 twice on Saturday 4/11/26 the first attempt he was too agitated and second attempt R1 had visitors. She would follow up to make sure this happens on Monday (4/13/26). She recommended 1:1 staff needed to are aware the change will happen. She indicated she was concerned if R1 could easily be able to get his seat belt off, he would stand up even with someone in the room and likely fall. She indicated she understood this is part of the state recommendation however she wanted to make sure they had a plan to keep him and staff safe. Upon interview on 4/8/26 at 11:11 a.m., nursing assistant (NA)-A stated she had never been told to release any of the residents on the unit who wore lap belts. R1 could remove his belt, because he often did it and staff would have to response, but he did not understand what the belt was for. R2 had never attempted to stand up or remove her alarm when NA-A had worked with her. R3 had complained about his bed alarm and was told by staff it was for his safety. Upon interview on 4/8/26 at 11:59 a.m. physical therapist (PT)-A stated it was the facilities standard of practice for anyone with a brain injury to get a lap belt and side rails placed upon admission. The reason for the restraints was because the residents could try to self-transfer and fall. Some residents need the lap belt because they are unable to understand how to call the nurse for help, if they release the belt the alarm would sound, and staff would assist. R1 could remove his belt, but he cannot remember things from day to day, was the reason he required the lap belt. The facility did not have it care planned that staff were to remove the seat belt as R1 could only walk with therapy assistance. R1 could follow only one step commands, he would become tired and then agitated so he could fall. Residents have side rails for turning and repositions and our beds are narrow, so the residents needed the rails to keep them safe from falling out of bed. Upon interview on 4/8/29 at 1:48 p.m. registered nurse (RN)-E stated all residents have the lap belts and side rails upon admission until they are assessed by therapy services. Nursing had nothing to do with any equipment assessments, Occupational and Physical Therapy completed equipment assessments. Upon interview 4/8/26 at 2:29 p.m. PT-B stated upon admission the residents did receive the lap belt and the side rails. The brain injury diagnosis the restraints were used was usually for forgetfulness and impulsiveness and the spinal cord injury residents diagnoses for the restraints for trunk support. Therapy assessed the residents usually within the first day of admission and would then assess the appropriateness of the lap belt and side rails. R1 was recommended to have the 24-hour remote observation, the seat lap belt, the bed alarm, and the side rails. R1 did not have the cognition to make himself safe so therapy implemented the safety devices. If R1 were to stand-up he would fall. The alarms were treating R1's impulsiveness. The seat belt alarm, the side rails, and the bed alarms were the least restrictive devices. Laps belts were not considered a restraint if the resident can remove it by themselves or ask someone else to remove it for them. The facility had different levels of belts, some disengaged easier than others. All facilities departments meet for daily interdepartmental meetings and discuss the needs of the residents. (PT)-B believed R2 could remove her lap belt, she stated if she cannot even though she is unable to speak, she could use her call light and could call for a nurse to assist her. R3 required the seat belt, side rails, and bed alarm due to falls. We need to have as many noises as possible, so we can get to the residents as soon as possible. Upon interview on 4/8/26 at 3:10 p.m. NA-A stated R1 took off his bed multiple times a shift. He did not understand what the belt was for, he would fidget with the belt when he was agitated. The staff only removed the lap belts for R1, R2, and R3 when they needed to use the bathroom or went to bed. Upon interview on 4/9/26 at 11:05 a.m. the nurse practitioner (NP) stated the lap belts; the side rails and the bed alarms were safety for the residents. Without the devices residents would fall. He was not certain what assessments therapy performed for the residents. He was not certain if any less restrictive devices had been attempted or what ongoing monitoring looked like. He did not order any of the devices. He signed whatever therapy assessed. He stated the medical diagnoses for R1, R2 and R3 would be cognitive concerns and impulsiveness. The residents did not have good judgement, which was the reason they had the devices, so they did not fall. Upon interview on 4/9/26 at 1:04 p.m. RN-B stated the standard process for admitting residents (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop a person-centered care plan that included all the medical devices in use and develop interventions for the safe use of the devices for 3 of 3 residents (R1, R2, and R3) who were reviewed for care plan development.Findings include: Upon observation and interview on 4/7/26 at 12:17 p.m. R1 was observed to have bilateral quarter side rails at the head of his bed and three-quarter length side rails at the foot of his bed. R1 was seated in his wheelchair with an alarmed seat belt around his waist on the back of his chair he had a wander guard bracelet attached to his wheelchair. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). R1's care plan dated 3/23/26 indicated R1 may use half side rails for positioning and safety when in bed. R1. The side rails were to be sued when he was in bed to allow for safe positioning due to spasms. His care plan did not indicate the side rails attached to the foot of his bed or any interventions for them. R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. The care plan did not indicate when the staff was to release the belt to give R1 freedom of movement. R1 had a wander guard (an electronic security system that uses a bracelet on a resident that alarms when the resident tries to wander outside the facility) that was not identified on the care plan or any intervention. Upon observation on 4/9/26 at 8:55 a.m. R2 was in bed, she had bilateral quarter side rails at the head of her bed, she had a seat belt alarm in her wheelchair and a wander guard bracelet attached to her wheelchair. R2's admission MDS dated [DATE] indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2's BIMS score was 00 indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent in toileting and transfers. Her pertinent diagnoses were cerebral infarction, aphasia, dysphagia, symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2's care plan dated 2/27/26 did not indicate R2 had bilateral quarter sized side rails, the seat belt alarm, or the wander guard. Upon observation and interview on 4/8/26 at 10:25 a.m. R3 was lying on his bed fully dressed. He stated he was fine with the alarm belt on his wheelchair and the alarm on his wheelchair when he left the unit, but he was bothered by the bed alarm. He stated he did not consent to put the alarm on his bed because it startled him and made him feel like he could not freely move his body when he was in bed. He struggled with sleep due to the alarm and feared that other residents in nearby rooms could hear his alarm when it sounded and disrupt their sleep as well. R3's admission MDS dated [DATE] indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction (stroke), dysphagia (difficulty swallowing) aphasia (impairment of a person's ability to process language, speak, read, write, and understand speech), abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's care plan dated 2/4/26 indicated R3 had a bed alarm, seat belt alarm to be on when in his wheelchair to aide in trunk support, grab bars/bedrails. Upon interview on 4/9/26 at 9:12 a.m. nursing assistant (NA)-A stated even though R2's devices were not on her care plan she knew what to do because most of the residents (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have the same equipment and she has been trained and used all of the equipment before. She stated the side rails are used for positioning, the belt is to always be on when residents are in their wheelchairs, and the wander guard was so residents could not leave the unit. Upon interview on 4/9/26 at 2:06 p.m. the director of nursing (DON) stated if all the devices are not on the care plan they should be. Upon interview on 4/13/26 at 3:22 p.m. the Administrator stated her expectation that all cares, services, and interventions were on each resident's care plan. A facility policy titled Person-Centered Care Planning dated 1/3/25 indicated:A comprehensive person-centered plan of care will be developed for each client within 7 days after completion of the comprehensive assessment and will include measurable objectives and times to meet a client's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive plan of care will minimally include: The services that are to be furnished to attain or maintain the client's highest practicable physical, mental, and psychosocial well-being. Any services recommended by the interdisciplinary team but refused by the client. The client's goals for admission and desired outcomes. The client's preference and potential for future discharge. Discharge plans1. The comprehensive care plan will be prepared by an interdisciplinary team that includes, but is not limited to:a. The attending providerb. An RN with responsibility for the clientc. A resident assistant with responsibility for the clientd. A member of food and nutrition services staffe. If practical the client and the client's representative. If not practical, document an explanation why the client or client representative are not part of the development of the plan of care.f. Other appropriate staff or professionals in disciplines as determined by the client's needs or as requested by the client.2. Review and revise the comprehensive plan of care after each assessment and include both the comprehensive and quarterly review assessments.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify environmental risks for stairwell doors that had nonfunctioning alarms, disabled locks, and failed to adequately supervise 1 of 3 residents (R1) through the remote monitoring system. This resulted in immediate jeopardy for 1 of 3 residents (R1) who opened a stairwell access door, wheeled through the door, and fell down six stairs while secured by a lap belt in his wheelchair. R1 sustained a hematoma (localized collected of clotted or partially clotted blood outside causing swelling, pain, and skin discoloration) and was sent to the emergency department for evaluation. In addition, the facility failed to have a system in place for routine checks on the fire door alarm system to ensure the employee badges and the resident wander guard (an alarm placed on or near the resident's body to alarm when they attempt to leave the unit) were in working order. This had the potential to affect all residents who resided in the unit. The Immediate Jeopardy (IJ) began on 4/1/26 when R1 fell down the facilities stairwell. The Administrator and the director of nursing were notified of the immediate jeopardy on 4/7/26 at 5:15 p.m. The immediate jeopardy was removed on 4/9/23 at 5:43 p.m., but noncompliance remained at the lower scope and severity, level 2, F - widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings include: Video surveillance of the incident on 4/1/26 at 4:06 p.m. showed R1 was coming out of his room in his wheelchair headed toward the emergency exit door. He pushed open the door with his left arm, going through the door placed both hands on either the brakes on his wheelchair or the arm rests then the emergency door closed. Two staff were walking into the nursing station office at 4:08 p.m. At 4:12 p.m. the staff walked to the emergency door, opened the door, and appeared to be calling for help. The video surveillance had no auditory recording. Upon observation and interview on 4/7/26 at 12:17 p.m. R1 was seated in his wheelchair in his room with a 1:1 staff. R1 recalled the fall stating he fell down about seven steps, but that is all he could remember. He did not recall whether he was in his wheelchair or not. Upon observation and interview with the maintenance engineer on 4/7/26 at 1:45 p.m. the maintenance engineer used his employee key card to open the door to observe the stairwell where R1 fell. The door opened to six stairs going down and stairs going up. After viewing the stairwell, the surveyor pushed onto the door, the door opened with no alarm sounding or badge use. The maintenance engineer stated that it was a concern, and he would be bringing it up at the following intradisciplinary team meeting the following day. He stated he was not aware that R1 had gotten through the door and fallen down the stairs. He was going to speak with his supervisor, who was at another location and see if he should secure the door until the facility could fix the alarm. R1's consent to remote observation dated 3/11/26 indicated R1 would be monitored remotely via a remote observation video and audio device that is monitored 24 hours a day by a trained observation technologist within the facilities health system. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke. R1's care plan dated 3/23/26 indicated R1 had a seat belt alarm, which was to be on when he was in wheelchair to aid in trunk support. R1's care plan did not include staff supervision until 4/1/26 following his fall. R1's care plan did not include R1 had a wander guard. R1's provider orders dated 4/1/26 indicated to discontinue the remote observation and start hourly rounding. R1's post-fall summary undated, indicated staff responded to a wander guard at the stairs, found R1 face down in (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the stairs with his wheelchair attached. R1 hit his head with a hematoma (a localized collection of clotted or pooled outside blood vessels caused by trauma, surgery or underlying vascular injury) forming. Emergency medical services were called and R1 was transferred to the hospital. R1's hospital after visit summary dated 4/1/26 indicated R1 was seen for a fall with a hematoma (localized collected of clotted or partially clotted blood outside causing swelling, pain, and skin discoloration) of the frontal scalp. R1's subsequent Transitional Rehabilitation Program note dated 4/2/26 indicated on 4/1/26 R1 was able to open a door to the stairway and fell down the first flight of stairs while still strapped to his wheelchair. He was sent for emergency evaluation. While in the Emergency Department he underwent a trauma workup and no significant injuries were found, besides a contusion on the front of his right forehead. He was set back to the facility that evening. At that time, he was placed on a 1:1 (a staff member would always be with R1). Prior to this he had remote observation. Upon interview on 4/7/26 at 2:00 p.m. the maintenance supervisor stated that the facility had not had the alarm in the stairwell in working order for months because the door did not need to be secure because the residents used the video surveillance system or the wander guard system (alarm placed on the resident that sounds an alarm when the resident is near a door). He was not aware of R1's fall. Upon interview on 4/7/26 at 2:31 p.m. R1's family member (FM)-A stated he was told that R1's remote observation alarm was delayed so R1 got out of his room without staff's awareness and by the time staff found him he had fallen down the stairs. When he visited staff would check on him, however not on a regular basis. (FM)-A used the unarmed door when he would visit R1 to enter and leave the facility, so he believed R1 thought that was his way out. Upon interview on 4/8/26 at 10:15 a.m. registered nurse (RN)-C stated R1's supervision was through the remote monitoring since the remote system watches residents 24 hours a day and redirects them for the staff on the unit. He would visualize R1 when he walks by his room, otherwise at shift change staff check in on all their residents. (RN)-C stated he was aware that the alarm on the door did not sound, and he did not have to use his badge to get through the door, he could not recall how long the door had been unarmed. (RN)-C did not notify anyone about the door, but management and other staff were able to walk through the door, so he did not think it was a concern. Upon interview on 4/8/26 at 10:35 a.m. the health unit coordinator (HUC) stated she was aware the door was unarmed. She did not report it to maintenance because she saw management use the door without their badge, so she assumed there were no concerns. Upon interview on 4/8/26 at 11:11 a.m. nursing assistant NA-A stated the supervision for R1 was the remote observation system because R1 was unable to use his call light to call for help. There were no criteria for checking on him and it would be unrealistic to check on him hourly because within the hour he could have fallen. She was unaware that the door was unarmed. Upon interview on 4/8/26 at 11:25 a.m. the security supervisor stated he came to the facility to check on the door. He stated the alarm had been turned off in March and turned back on 4/1/26. He stated he was not certain how the facility checked for the doors to be working. He could see that multiple staff continued to use their badge since the alarm was shut off. Upon interview on 4/8/26 at 12:25 p.m. the offsite remote observation supervisor stated her team did an investigation, and they found their team member did not follow the work standard. The technician who was watching R1 walked away from his desk and within a few seconds R1 had left his room. When the technician saw R1 was not in his room he called the charge nurse at the facility. The protocol should have been to have sounded the remote alarm so the facility would have heard the alarm and searched for R1 more quickly. Upon interview on 4/8/26 at 1:36 p.m. RN-D stated R1's supervision was the remote observation, the chair and bed alarms. He was wondering why he no longer needed to use his badge for the door, but thought management had made a change. Upon interview on 4/8/26 at 1:48 p.m. RN-E stated a little after 4:10 on 4/1/26 he received a call from the remote observation technician and what he thought the technician said was that R1 had left his room with a facility staff member so RN-E was not concerned. A few seconds later he heard a wander guard alarm sound. He ran to the door and found R1 had fallen down the first set of stairs in the stair well. R1 was face down with his (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wheelchair on top of him. He had to cut R1's lap belt off him. R1 was conscious, emergency medical services were called and R1 was taken to the hospital. RN-E stated after R1 was transferred to the hospital he was informed by NA-B that R1 had increased agitation and had attempted to leave the building the prior day. Upon interview on 4/8/26 at 3:10 p.m. NA-B stated she worked the evening R1 fell. She also responded to the wander guard alarm and found R1 face down with his wheelchair attached to him. R1 was supervised with the remote observation and his alarms, but they failed him on 4/1/26. Upon interview on 4/9/26 at 11:05 a.m. R1's Nurse Practitioner (NP) stated the facility uses multiple devices for all the residents for their safety. He stated after the fall he ordered staff to also supervise R1. Upon interview on 4/9/26 at 1:04 p.m. RN-B stated R1's supervision was the remote observation unit, and he should have been on hourly rounding as well. The facility was thinking of stopping the remote observation as they felt it was agitating R1 more. The wander guard alarm was started prior to the fall on 4/1/26 due to increased agitation and R1 attempting to elope out the same door the previous day. RN-B was not aware the door alarm had been turned off. Upon interview on 4/9/26 at R1's medical provider stated he was aware that R1 had gotten through the door and fell with his wheelchair attached to him. He could not be certain how having R1 belted into his chair could have changed the fall. He was not aware the emergency alarm on the door was not working and if they could have prevented the fall either. He stated the door needed to be fixed and even with all the devices staff should also be supervising the residents. Upon interview on 4/13/26 at 10:26 a.m. the Administrator stated the staff supervise the residents even with the use of the remote observation and alarms. She believed R1 was being supervised every hour by staff. Secure Care Products (wander guard) user manual with a revision date of 11/16/07 indicated Secure Care's software, parts and products have been designed to augment a facility's reasonable procedures for protecting residents, patients, and infants. However, no system or combination of procedures and equipment can eliminate all risk or assure complete security. Secure Care's system is not intended as a substitute for the careful identification and monitoring of residents, patients, and infants by a facility's professional staff. The manual indicated that weekly testing of wandering patients should be tested to make sure the transmitter is working.-Monthly testing should be performed for the fire alarm release feature.-The annual service was recommended to be sure the battery was replaced.-Onguard user guide (the employee badge alarm locks) dated 1/2005 indicated how to set up the alarms and how to check the arms but did not indicate how often a facility should be checking the alarms. Allegion user guide dated 2021 indicated The Von Duprin Chexit device is designed for controlled egress applications. It meets both life safety and security needs, as well as the requirements of NFPA101 for Special Locking Arrangement and IBC Special Egress-Control Devices. All control inputs, auxiliary locking, local alarm and remote signaling outputs are self-contained in the Chexit assembly. Numerous field configurable options allow the device to be customized for the specific code or application requirements. The standard Chexit device sounds an alarm and keeps the door secured for 15 seconds following an exit attempt with immediate release upon fire. The manual indicated how to test the powerup, the delayed egress and an advanced function test, however, did not indicate how often a facility should be testing the devices. Policies regarding accidents and equipment inspections were requested, however none was received. The Immediate Jeopardy (IJ) began on 4/1/26 when R1 fell down the facilities stairwell. The Administrator and the director of nursing were notified of the immediate jeopardy on 4/7/26 at 5:15 p.m. The immediate jeopardy was removed on 4/9/23 at 5:43 p.m., when the facility trained all staff about reporting when they are aware a door is unarmed. The facility made plans to make the second emergency door into an armed door to mirror the door R1 went out of. The facility placed signs on the unarmed door and used remote observation 24 hours a day to alarm if a resident or staff attempted to use the door. Staff were educated to respond immediately when they heard the remote alarm sound. The facility audited staff to ensure staff responded. but noncompliance remained at the lower scope and severity, level 2, F - widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

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F 0846 Level of Harm - Potential for minimal harm Residents Affected - Many	Have policies and procedures ensuring the administrator's responsibilities for facility closure are completed successfully. Based on interview and document review, the facility failed to ensure a facility closure policy and procedure had been developed. This had the potential to affect all residents residing in the building.Findings include:A policy and procedure covering facility closure was requested from the facility, but facility failed to provide such documentation.Email correspondence dated 4/7/26 at 8:16 p.m. the Administrator indicated the facility did not have a policy/procedure on facility closure, as the facility had no intent to close.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as a part of the regular maintenance program to identify areas of possible entrapment for 3 of 3 residents (R1, R2, and R3) reviewed for side rails. The facility did not provide any documentation of inspection or entrapment assessments.Findings include: Recommendations for Health Care Providers Using Adult portable Bed Rails dated 2/27/2023 retrieved on 4/13/26 from https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/hospital-beds indicated, when evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care https: Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. Bed safety programs may also include plans for the reassessment of hospital bed systems. Reassessment may be appropriate when (1) there is reason to believe that some components are worn (e.g., rails wobble, rails have been damaged, mattresses are softer) and could cause increased spaces within the bed system, (2) when accessories such as mattress overlays or positioning poles are added or removed, or (3) when components of the bed system are changed or replaced (e.g., new bed rails or mattresses). This guidance describes seven zones in the hospital bed system where there is potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. Descriptions of the seven entrapment zones appear on pages 15-21 in this guidance. Summary drawings of entrapment for all the zones appear in Appendix E. The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below. Zone 1: Within the Rail Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support Zone 3: Between the Rail and the Mattress Zone 4: Under the Rail, at the Ends of the Rail Zone 5: Between Split Bed Rails Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board Zone 7: Between the Head or Foot Board and the Mattress End. Health Care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. The manufacture user-service manual for [NAME] Hill-Rom [NAME] Medical-Surgical Hospital Bed, undated, indicated Warning-Evaluate patients for entrapment and fall risk according to facility protocol, and/or healthcare provider directives, and monitor patients appropriately. Make sure all side rails are fully latched when in the raised position. Failure to do either of these could cause serious injury or death. Do annual preventive maintenance procedures to make sure the [NAME] Smart+ Bed operates as originally designed. The procedures include examinations of these:Overall condition SiderailsControls (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and motorsBattery Backup Brakes and casters [NAME] systemHead angle displayCommunication systemTransport systemTransport system batteries MattressAccessoriesWARNING:To help prevent serious injury and/or death, obey these warnings:Warning-Evaluate patients for entrapment and fall risk according to facility protocol and monitor patients appropriately.Warning-Make sure that all side rails are fully latched when in the raised position.Warning-Stay clear of pinch points and moving parts during siderail operation.Siderails are intended to be a reminder to the patient of the bed's edges, not a patient-restraining device. When appropriate, Hill-Rom recommends that medical persons determine the correct methods necessary to make sure a patient stays safely in bed.Siderails in the raised position are intended to make the patient aware of the proximity of the edge of the mattress and to assist in patient entry and exit.R1's Physical Device assessment dated [DATE] indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability appropriately using the device as applicable. The device did not restrict voluntary freedom of moment or prevent access to any part. His decision made him understand the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried. Upon observation and interview on 4/7/26 at 12:17 p.m. R1 was seated in his room in wheelchair. He had bilateral quarter rails at the top of his bed that were in the upright position. He had bilateral three-quarter length side rails at the bottom of bed that were lowered. R1 stated, he did not know what the side rails were, but they were on the bed he slept in. He then started speaking nonsensical about having to leave for work and repair cars. R1's Physical Device assessment dated [DATE] indicated R1 had left and right quarter side rails. R1 was able to demonstrate ability appropriately use the device as applicable. The device did not restrict voluntary freedom of moment or prevent access to any part. His decision made him understand the risk and benefits of the device. R1's symptoms were weakness, impaired mobility, impulsive movements, cognitive deficits, sensory deficits, impaired judgement, hemiplegia, fatigue, rehab, to facilitate independence and unable or unwilling to acknowledge impairments. R1's diagnosis was cerebral vascular accident (CVA). No less restrictive devices were tried. R1's physical therapy assessments and notes dated 3/11/26 - 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R1's occupational therapy assessments and notes dated 3/11/26 - 4/6/26 did not indicate side rails were in use for R1 or any entrapment assessment. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 6 indicating he was significantly cognitively impaired. R1 required moderate assistance with dressing, sitting to standing, chair to bed transfer, toilet transfer, walking 150 feet. R1 used a wheelchair. R1 was always continent of bowel and bladder. R1's pertinent diagnoses were cerebral infarction (stroke), weakness, acute respiratory failure, dysphagia (difficulty swallowing), dysarthria (motor speech disorder), paralytic gait (abnormal walking), and neurological neglect syndrome (brain damage usually following a stroke). MDS did not include use of bedside rails. R1's care plan dated 3/23/26 indicated R1 may use half side rails for positioning and safety when in bed. No other documentation related to the use of side rails was indicated. Upon observation and interview on 4/9/26 at 8:55 a.m. R2 was in bed, two nursing assistants were changing her incontinent brief and getting her dressed for the day. R2 had bilateral quarter sized side rails at the head of her bed. She was unable to roll herself in bed, staff assisted her to roll on her right side, and she held on to the side rail with her left hand throughout the cares. R2 was unable to move the right side of her body. R2 was only able to interview by nodding yes or no to questions. R2 indicated through nodding that she could not use her right hand, that she could not turn herself in bed and that she used the side rails when staff assisted her. She could not remove the side rails by herself. R2?s Physical Device assessment dated [DATE] indicated R2 had quarter size left and right-side rails. She was able to demonstrate the ability to use the device appropriately and they did not restrict her voluntary freedom of movement or prevent access to a body part. Her decision (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	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courage Kenny Rehabilitation Institutes Trp	3915 Golden Valley Road Golden Valley, MN 55422

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

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understood the risk and benefits. R1's symptoms were weakness, impaired mobility, hemiplegia, rehab, to facilitate independence. Her diagnoses of CVA and no less restrictive devices were tried. There was no documentation for any entrapment assessments. R2's physical therapy assessments and notes dated 2/27/26 - 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R2's occupational therapy assessments and notes dated 2/27/26 - 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R2's care plan dated 2/27/26 did not indicate the use of side rails. R2's admission MDS dated [DATE] indicated R2 was unable to speak, she sometimes could make herself understood and sometimes had the ability to understand others. R2's BIMS score was 00 indicated severe cognitive impairment. R2 required moderate assistance with upper body dressing, oral hygiene and eating. Maximum assistance with lower body dressing, rolling in bed, sitting to lying and lying to sitting on the edge of the bed. She was dependent in toileting and transfers. Her pertinent diagnoses were cerebral infarction, aphasia, dysphagia, symptoms and signs of cognitive functioning and abnormalities of gait and mobility. R2's MDS did not indicate the use of the side rails. Upon observation and interview on 4/9/26 at 10:25 a.m. R3 was resting on his bed fully dressed. He had bilateral half rails at the head of his bed. He stated he could reposition himself in bed and use the rails. R3's Physical Device assessment dated [DATE] indicated R2 had right and left quarter sized rails on his bed. He was able to demonstrate the ability to use the device appropriately and it did not restrict any voluntary freedom of movement or prevent access to any body part. Client and our decision maker did not say they understood the risk and benefits. R3's symptoms were impaired judgement and hemiplegia. No other alternatives were tried. R3's diagnosis was a CVA, and no less restrictive devices were tried. R3's summary indicated quarter side rails on bed to help with turning and reposition. There was no documentation for any entrapment assessments. R3's physical therapy assessments and notes dated 2/2/26 - 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R3's occupational therapy assessments and notes dated 2/2/26 - 4/8/26 did not indicate side rails were in use for R1 or any entrapment assessment. R3's care plan dated 2/9/26 did not indicate the use of side rails. R3's admission MDS dated [DATE] indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 required moderate assistance for dressing and personal hygiene. He was dependent for toileting hygiene and transfers. He could roll from side to side in bed with moderate assistance. R3's pertinent diagnoses were cerebral infarction, dysphagia, aphasia, abnormalities of gait and mobility, weakness, and other signs of cognitive functioning. R3's MDS did not indicate the use of side rails. On 4/9/26 at 10:45 a.m. a request was made to the maintenance engineer for any documentation of assessments or inspections of resident side rails. No documentation was received. On 4/9/26 at 11:22 a.m. a request was made to the administrator for any documentation of assessments or inspections of resident side rails. She stated she would send the information. No information was received. Upon interview on 4/7/26 at 12:41 p.m. registered nurse (RN)-A stated she was unaware of any safety precautions or inspections on the side rails. She stated therapy was in charge of all equipment. She was not certain if R1 used the lower side rails or if they just were not removed from his bed upon his admission. Upon interview on 4/7/26 at 1:48 p.m. the maintenance engineer stated he had not done anything with side rails expecting to fix them when nursing reports they are broken. Upon interview on 4/8/26 at 11:59 a.m. Physical Therapist (PT)-A stated residents who have a brain injury are all admitted with side rails and a lap belt and then when they saw therapy for the first time devices could be adjusted. She stated nursing would complete any assessments for safety such as the zoning in the bed. A facility policy titled Restraints dated 1/23/24 indicated safety devices are used to enable the residents to attain or maintain their highest level of independent functioning and safety. The decision to use these aids and positioning devices is made through resident participation in individual assessment and care planning by the interdisciplinary team. They are used only with resident consent and under physician order and direction.PROCEDURE:1) The interdisciplinary team conducts an individual assessment/evaluation to determine the need for any positioning/potentially restraining/safety (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	device. A care plan is developed to identify the residents' needs and parameters for use of the device, i.e., bed rails up at night so residents may use it to assist with turning. This care plan is reviewed at least quarterly and updated as needed.2) Prior to implementing the care plan, the nurse will review the risks and benefits of the use of the device with the residents. The resident, or if unable, the resident representative, signs the informed consent.The policy did not indicate any inspection timing of the devices.