DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 8, 2019

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

RE: Project Number H5207042C

Dear Administrator:

On August 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. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
July 19, 2019

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

RE: Project Number H5207042C

Dear Administrator:

On June 28, 2019, an abbreviated survey was completed at your facility by the Minnesota Departments 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E)

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is August 7, 2019.

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));

- 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), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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 September 28, 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 December 28, 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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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,

Kamala Fiske-Downing

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Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING _____ B. WING _____	C 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	**1119 OWENS STREET NORTH STILLWATER, MN 55082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/26, 6/27 and 6/28/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5207042C 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions	F 689	Preparation and execution of this response and plan of correction does not	7/29/19

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

Electronically Signed | 07/24/2019

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F 689	Continued From page 1 identified to prevent falls were implemented for 1 of 1 resident (R1), and failed to ensure the safe use of grab bars/bed rails to minimize the risk of accidents 3 of 3 resident (R2, R3, R1). Findings include: R2's face sheet identified diagnoses including: dementia, depression, anxiety disorder, kidney disorder, history of stroke with right side hemiplegia and hemiparesis, and history of falls. R2's annual Minimum Data Set (MDS) assessment dated 5/3/19, indicated R2 had moderately impaired cognition and required extensive assistance of 2 staff for bed mobility, dressing, toileting, and total dependence of 2 staff for transfers.The MDS did not identify R2 used bed rails for bed mobility. During an interview with family member (FM)-A on 6/26/19, at 3:05 p.m., FM-A acknowledged visiting R2 at least 5 days per week. FM-A reported R2 had experienced a fall from his bed on 6/13/19 at 5:50 a.m. while receiving care. FM-A stated R2 had moderate confusion, and could not remember details of his fall but stated after the fall, R2 developed a hematoma on the underside of his right elbow. In addition, FM-A said R2's arm turned dark, blackish-purple from the mid upper arm to the hand. FM-A displayed a picture of R2's arm on her cell phone. The image of R2's right arm depicted dark, blackish-purple discoloration extending from R2's mid upper arm to the hand. FM-A further stated R2 required an x-ray of his arm, but no fracture was identified. FM-A stated since the fall, R2 had experienced an increase in pain in the right arm, had stopped	F 689	constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. R1, R2, & R3□s care plans have been reviewed after assessments completed for appropriate need for assist bars. 2. Care plans for all residents in the building have been reviewed and updated to reflect appropriate need for assist bars after completion of assessments. Assessments will be completed upon admission, re-admission, annually, quarterly, with significant change in condition, per the RAI manual guidelines, and prn going forward, to ensure continued use is safe and appropriate. Care plans will be updated with changes. 3. All Licensed nurses will be educated on the correct policy and procedure for implementing assist bars and notifying Environmental Services of concerns with equipment.	

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F 689	Continued From page 2 feeding himself, now requiring total assistance of 1 staff to eat and drink. FM-A stated R2 had experienced a gradual decline in his health prior to his fall out of bed, and FM-A stated R2 was "giving up." An Incident Report dated 6/13/19, indicated R2 had rolled over in bed while one nursing assistant, (NA)-D, was providing care to change R2's incontinence brief. The report indicated while turning to his side, R2 had attempted to grab the bed rail and missed, rolling out of bed onto the floor. According to the report, licensed practical nurse (LPN)-A had arrived to the room and found R2 sitting on the floor facing the door with his legs underneath him, and his left arm was caught between the mattress and grab rail attached to the bed. The report indicated R2 sustained a small skin tear on his upper right chest, and was unable to report how he fell from bed. Although requested, no post fall investigative documentation was provided. R2's progress note on 6/14/19, identified R2's fall was reviewed by the interdisciplinary team. (IDT). The nurse manager was delegated to observe and assess R2's turning needs. There was no documentation of such assessment having been conducted. Observation of R2's bed on 6/26/19 at 3:20 p.m., identified quarter bed rails were in place on R2's bed. The measurements between the bars within the perimeter were 4 1/2 inches vertically by 6 inches horizontally within the area of the bar toward the head of the bed, and 4 1/2 inches vertically and 12.5 inches horizontally within the perimeter area toward the footboard. The quarter	F 689	4. Audits will be conducted by DNS or designee via observation and chart review to ensure appropriate use of assist bars and to ensure appropriate assessments are completed prior to implementation of assist bars as well as updated care plans. These audits will be completed on 5 random residents and be completed weekly x4, then monthly x2. Results will be taken to the QAPI committee monthly meeting for review and further recommendations.	

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F 689	Continued From page 3	F 689		

rails were connected to the bed frame at a single point and had a vertical gap 18 inches from the bed frame at the point of attachment. The grab bar was loose when pressure was applied to the ends of the rails. R2's bed also had a gap guard at the foot of the bed to keep the mattress snug on the bed frame.

R2's care plan identified R2 used assist bars for bed mobility and required total assistance of 2 staff to turn to side. The care plan further indicated R2 required extensive assist of 2 staff for personal cares and repositioning.

R2's current physician orders did not include an order for bed rails, and the medical record did not include documentation R2 and/or R2's representative had been provided sufficient information about risks and benefits so an informed decision could be made about the use of the rails.

A Positioning Assessment and Evaluation dated 5/10/19, identified R2 was dependent on staff for transfers and repositioning. The assessment indicated R2 was able to hold onto the grab bar when on his side, and indicated R2 had multiple diagnoses affecting positioning including hemiparesis and vascular dementia. The assessment noted R2 had right sided weakness in his hand, arm and leg, but his left arm was strong. R2 was identified as alert, oriented to person, place and time, and could communicate and follow commands.

During interview with licensed practical nurse (LPN)-A on 6/28/19 at 7:56 a.m., LPN-A stated she was the nurse who had responded to R2's

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F 689	Continued From page 4 fall, but was not present during the fall. LPN-A said when she'd entered the room, R2 was sitting on the floor facing the door, with his arm on the bed partially wedged between the mattress and the bed rail. LPN-A said she had gently released the R2's arm and stated he was able to assist her. LPN-A stated although R2's neurological status was assessed as normal at that time, he was unable to explain what happened. LPN-A stated NA-C, the only staff in the room at the time of the fall, had reported R2 had not hit his head during the fall, but had reached for the grab rail, missed and rolled out of bed. LPN-A verified R2 had sustained a skin tear on his right chest, but stated she hadn't measured it. An incident report and fall report were completed following the fall. Family, the physician, director of nursing (DON) and nurse manager were notified. However, LPN-A stated she had not notified maintenance of R2's arm getting caught between the grab bar and mattress, and had not completed a repair request for the side rail to have it checked for safety. LPN-A further stated when residents were assessed for side rails, staff looked at them to see if they could get out of bed and if the resident needed side rails, they communicated with the day shift to notify the nurse manger. LPN-A was unaware of any other facility process for bed rail safety assessments, and stated since the facility only used grab bars, they had not felt assessments were required. An attempt was made on 6/27/19 at 3:00 p.m., to interview NA-C without any response. At that time the DON was asked to have NA-C contact the surveyor. However, the DON stated NA-C was on vacation until the following week.	F 689		

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F 689	Continued From page 5 During interview with the environmental services director (ED) on 6/27/19, at 12:35 p.m., he verified the measurements of the quarter rails but stated he was unsure whether they met safety recommendations to prevent resident entrapment. ED stated he was unaware R2's arm had been trapped between the bed rail and mattress following the fall on 6/13/19, and was unsure whether the bed rail had been checked for safety after the fall. ED stated the facility had utilized many types of bed rails on the beds,and was unsure of the facility process to determine whether a bed rail met safety requirements for resident use. ED also confirmed there was no routine audit/safety checks conducted by environmental services staff to verify the bed rails were maintained in safe working order. He was unsure who was responsible for monitoring resident equipment for safety but stated the nursing staff notified the maintenance department by email, or with written repair requests, to add, remove or repair resident equipment. At that time, the ED observation of R2's bed rails with the surveyor and the ED agreed R2's bed rails had some "play," which he identified as "normal". At 1:30 p.m. on 6/27/19, the ED confirmed there was no policy or procedure in place to identify when bed rails should be inspected for resident safety and stated there was no maintenance schedule for maintaining bed rails, bed frames, and mattresses. If maintenance was required for an in use bed rail, the nursing department was expected to complete a repair request either on a written document or sent by email. In addition, the ED stated bed rails were not inspected by his department for compatibility with bed frames, and were not reviewed for fit. The ED was not able to	F 689		

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F 689	Continued From page 6	F 689		

locate the manufacturer information for the beds or quarter side rails, again stating the facility used several different types of bed rails: Some bed rails came with the beds, and some were ordered separately. The ED stated the bed rails remained on the beds at all times and if nursing staff wanted them removed, the ED expected nursing staff to notify them with a work order for removal.

Observation of R3's bed with the director of nursing (DON) on 6/27/19 at 4:30 p.m., identified bed rails in use on both sides of the head of R3's bed. The bed rails were quarter rails and had a parallelogram shape. The rail measurements within the perimeter of the bed rail were 4 inches apart vertically and 6 inches horizontally. The bed was observed to be controlled electronically by a control panel on the footboard side of the bed rail. The DON identified the bed rails were in use to enable staff to adjust the bed, and verified as such, no safety assessment, consent, or physician orders had been obtained prior to placing the side rail into use.

During interview with the DON on 6/27/19 at 4:40 p.m., the DON verified R2 and R3's quarter bed rails had not been assessed for safe use prior to placing them on the residents' beds. The DON stated physical therapy (PT) did not evaluate bed rail use, and they had not obtained physician orders for use. Further, the DON stated after R2's fall, maintenance had not been notified, and had not conducted an inspection of the bed rails to ensure they were securely fit to the bed. The DON stated she'd been updated about R2's incident and had reviewed the Incident Report with the interdisciplinary team (IDT) on 6/14/19.

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F 689	Continued From page 7	F 689		

The DON reviewed R2's electronic medical record and post fall documentation and was unable to verify R2's bed rail was assessed for safety, and appropriateness of use. The DON stated NA-C was a newly hired employee in the facility an had received orientation to safe resident handling, however verified safe resident handling did not include bed mobility.

LPN-B was interviewed on 6/28/19 at 9:35 a.m., and stated when they initiated the quarter bed rails for resident use, the floor nurse was suppose to complete a sit/stand assessment or a transfer and positioning assessment, document in the computer and communicate the information to the nurse manager and DON. LPN-B stated she thought the request was then reviewed by the IDT. She further stated injuries involving equipment were documented on an internal incident report, and communicated to the DON, administrator, nurse manager, family, and providers. The nurse managers and DON would then review any incident reports with the IDT team to identify concerns, update care plans, and provide education when needed. Changes in resident care plans were communicated to NAs during shift report and through verbal communication, and NAs had access to care plans via the facility's electronic documentation system. LPN-B also stated when grab bars were identified to be appropriate, providers were contacted to request a physical therapy (PT) order to assess needs. LPN-B stated the facility did not complete routine bed rail safety monitoring because the facility only used quarter rails, grab bars which were always on the beds. She stated they were not routinely removed from a bed when a resident was discharged and

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F 689	Continued From page 8	F 689		

acknowledged when a resident was admitted, if the bed rails were still on the bed, they usually remained there.

Upon observation of R1's quarter bed rail with the DON on 6/28/19 at 3:39 p.m., the bed rail dimensions were the same as those of the quarter rails on R2's bed: The measurements between the bars within the perimeter were 4 1/2 inches vertically by 6 inches horizontally within the area of the bar toward the head of the bed, and 4 1/2 inches vertically and 12.5 inches horizontally within the perimeter area toward the footboard. The quarter rails were connected to the bed frame at a single point and had a vertical gap 18 inches from the bed frame at the point of attachment. The grab bar was loose when pressure was applied to the ends of the rails.

Interview with the medical director (MD) on on 6/28/19, at 11:10 a.m., identified her expectation for bed rails was for the facility to contact physical therapy or occupational therapy to evaluate residents' need for using a bed rail to ensure residents were truly be able to be able to assist in movement before putting bed rails into use. She expected the facility to obtain an order for PT or OT to evaluate any bed rail to assess for use and safety before putting them into use.

Review of the facility's 5/17, Bed Safety Policy indicated bed rail usage would occur only when medically necessary, as documented by the provider, and when the total bed environment (bed frame, mattress, bed, rails, and overlays) were inspected and verified to be free of entrapment risk. The policy also indicated annual inspections of bed frames, mattresses and bed

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	**1119 OWENS STREET NORTH STILLWATER, MN 55082**

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F 689	Continued From page 9	F 689		

rails (side rails, assist bars, and transfer devices) were indicated to identify and eliminate any potential entrapment issues, and to ensure bed rails were compatible with the bed frame and mattress. The policy indicated these inspections were to be documented. The facility was to consider whether an alternative to side rails could be used. Assessments were to include, but were not limited to, the use of the Physical Device and Restraint Assessment, Section G of the MDS, and input from the physical therapist and restorative nurse. A bed inspection kit was available from the Good Samaritan National Campus Resource Library, and an on line focus audit was available for bed and safety use. Mattresses were inspected for movement on the platform. Movement of several inches constituted a safety hazard. In instances where a gap between the mattress and headboard, footboard, or side rail was greater than 4 inches, a gap guard to reduce the gap was a temporary, acceptable use until a suitable mattress was obtained. Residents with medically necessary bed rails were to have bed rails placed in beds of the same manufacturer as the bed and installed according to the manufacturer's directions. No more than 4 inches between the bottom side of the bed rail and tip of the mattress then the rail was in the up position was allowed. Bed rail bars were also not to be more than four inches apart. When an appropriate order was received for bed rails, only quarter rails were to be used.

A policy and procedure was requested for maintenance of equipment. No policy was provided.

The Guidance for Industry and FDA (Federal

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F 689	Continued From page 10 Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment manual dated 3/10/06, identified Zone 1 as the area, "any open space within the perimeter of the rail". It also noted HBSW [Hospital Bed Safety Workgroup] and IEC [International Electrotechnical Commission] recommend the space be less than 4 3/4 inches.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately assess, and obtain consent for the use of bedrails for 3 of	F 700	1. R1, R2, and R3□s quarter rails have been removed from their beds. R1, R2, R3 have been re-assessed for the need	7/29/19

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F 700	Continued From page 11 3 residents (R2, R3 and R1) reviewed who utilized quarter side rails for assistance with bed mobility,and failed to ensure the bed rails fit the bed appropriately and were used in accordance with FDA and manufacturer guidance. The deficient practice had the potential to affect 43 of 58 residents currently residing in the facility who utilized some form of bedrail. Findings include: During an interview with family member (FM)-A on 6/26/19, at 3:05 p.m., FM-A acknowledged visiting R2 at least 5 days per week. FM-A reported R2 had experienced a fall from his bed on 6/13/19 at 5:50 a.m. while receiving care. FM-A stated R2 had moderate confusion, and could not remember details of his fall but stated after the fall, R2 developed a hematoma on the underside of his right elbow. In addition, FM-A said R2's arm turned dark, blackish-purple from the mid upper arm to the hand. FM-A displayed a picture of R2's arm on her cell phone. The image of R2's right arm depicted dark, blackish-purple discoloration extending from R2's mid upper arm to the hand. FM-A further stated R2 required an x-ray of his arm, but no fracture was identified. FM-A stated since the fall, R2 had experienced an increase in pain in the right arm, had stopped feeding himself, now requiring total assistance of 1 staff to eat and drink. FM-A stated R2 had experienced a gradual decline in his health prior to his fall out of bed, and FM-A stated R2 was "giving up." An Incident Report dated 6/13/19, indicated R2 had rolled over in bed while one nursing assistant, (NA)-D, was providing care to change	F 700	of an assist bar. All other residents with quarter rails have had rails removed and have been re-assessed for the need of an assist bar. All care plans have been updated appropriately. 2.All residents in the building will be assessed for appropriate need of assist bars. Bed inspections will be completed on new equipment before putting into circulation and prn with equipment changes. 3. All facility beds have bed tested using the bed inspection kit. Results will be stored by the Environmental Service Director. All Licensed nurses will be educated on the correct policy and procedure for implementing assist bars and notifying Environmental Services of concerns with equipment. 4. Bed Assessment and Side Rail Safety Audit will be completed by Environmental Services Director or designee via observation and chart reviews to ensure assist bars fit the bed appropriately and are used per policy and procedure. These audits will be completed weekly x4, then monthly x2. Results will be taken to the QAPI committee monthly meeting for review and further recommendation.	

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R2's incontinence brief. The report indicate while turning to his side, R2 had attempted to grab the bed rail and missed, rolling out of bed onto the floor. According to the report, licensed practical nurse (LPN)-A had arrived to the room and found R2 sitting on the floor facing the door with his legs underneath him, and his left arm was entrapped between the mattress and half rail attached to the bed. The report indicated R2 sustained a small skin tear on his upper right chest, and was unable to report how he fell from bed. Although requested, no post fall investigative documentation was provided.

R2's progress note on 6/14/19, identified R2's fall was reviewed by the interdisciplinary team. (IDT). The nurse manager was delegated to observe and assess R2's turning needs. There was no documentation of such assessment having been conducted.

R2's face sheet identified diagnoses including: dementia, depression, anxiety disorder, kidney disorder, history of stroke with right side hemiplegia and hemiparesis, and history of falls.

R2's annual Minimum Data Set (MDS) assessment dated 5/3/19, indicated R2 had moderately impaired cognition and required extensive assistance of 2 staff for bed mobility, dressing, toileting, and total dependence of 2 staff for transfers. The MDS indicated R2 had been able to eat independently after staff assisted with setting up his meals. The MDS did not identify R2 used bed rails for bed mobility.

Observation of R2's bed on 6/26/19 at 3:20 p.m., identified quarter bed rails were in place on R2's

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bed. The measurements between the bars within the perimeter were 4 1/2 inches vertically by 6 inches horizontally within the area of the bar toward the head of the bed, and 4 1/2 inches vertically and 12.5 inches horizontally within the perimeter area toward the footboard. The quarter rails were connected to the bed frame at a single point and had a vertical gap 18 inches from the bed frame at the point of attachment. The grab bar was loose when pressure was applied to the ends of the rails. R2's bed also had a gap guard at the foot of the bed to keep the mattress snug on the bed frame.

R2's current physician orders did not include an order for bed rails, and the medical record did not include documentation R2 and/or R2's representative had been provided sufficient information about risks and benefits so an informed decision could be made about the use of the rails.

A Positioning Assessment and Evaluation dated 5/10/19, identified R2 was dependent on staff for transfers and repositioning. The assessment indicated R2 was able to hold onto the grab bar when on his side, and indicated R2 had multiple diagnoses affecting positioning including hemiparesis and vascular dementia. The assessment noted R2 had right sided weakness in his hand, arm and leg, but his left arm was strong. R2 was identified as alert, oriented to person, place and time, and could communicate and follow commands.

During interview with licensed practical nurse (LPN)-A on 6/28/19 at 7:56 a.m., LPN-A stated she was the nurse who had responded to R2's

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fall, but was not present during the fall. LPN-A said when she'd entered the room, R2 was sitting on the floor facing the door, with his arm on the bed partially wedged between the mattress and the bed rail. LPN-A said she had gently released the R2's arm and stated he was able to assist her. LPN-A stated although R2's neurological status was assessed as normal at that time, he was unable to explain what happened. LPN-A stated NA-C, the only staff in the room at the time of the fall, had reported R2 had not hit his head during the fall, but had reached for the grab rail, missed and rolled out of bed. LPN-A verified R2 had sustained a skin tear on his right chest, but stated she hadn't measured it. An incident report and fall report were completed following the fall. Family, the physician, director of nursing (DON) and nurse manager were notified. However, LPN-A stated she had not notified maintenance of R2's arm getting caught between the grab bar and mattress, and had not completed a repair request for the side rail to have it checked for safety. LPN-A further stated when residents were assessed for side rails, staff looked at them to see if they could get out of bed and if the resident needed side rails, they communicated with the day shift to notify the nurse manger. LPN-A was unaware of any other facility process for bedrail safety assessments, and stated since the facilty only used grab bars, they had not felt assessments were required.

An attempt was made on 6/27/19 at 3:00 p.m., to interview NA-C without any response. At that time the DON was asked to have NA-C contact the surveyor. However, the DON stated NA-C was on vacation until the following week.

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F 700	Continued From page 15 During interview with the environmental services director (ED) on 6/27/19, at 12:35 p.m., he verified the measurements of the bed rails but stated he was unsure whether the quarter bed rails met safety recommendations to prevent resident entrapment. ED stated he was unaware R2's arm had been trapped between the bed rail and mattress following the fall on 6/13/19, and was unsure whether the bed rail had been checked for safety after the fall. ED stated the facilty had utilized many types of bed rails on the beds,and was unsure of the facility process to determine whether a bed rail met safety requirements for resident use. ED also confirmed there was no routine audit/safety checks conducted by environmental services staff to verify the bed rails were maintained in safe working order. He was unsure who was responsible for monitoring resident equipment for safety but stated the nursing staff notified the maintenance department by email, or with written repair requests, to add, remove or repair resident equipment. At that time, the ED observation of R2's bed rails with the surveyor and the ED agreed R2's bed rails had some "play," which he identified as "normal". At 1:30 p.m. on 6/27/19, the ED confirmed there was no policy or procedure in place to identify when bed rails should be inspected for resident safety and stated there was no maintenance schedule for maintaining bed rails, bed frames, and mattresses. If maintenance was required for an in use bed rail, the nursing department was expected to complete a repair request either on a written document or sent by email. In addition, the ED stated bed rails were not inspected by his department for compatibility with bed frames, and	F 700		

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were not reviewed for fit. The ED was not able to locate the manufacturer information for the beds or quarter side rails, again stating the faciltiy used several different types of bed rails: Some bed rails came with the beds, and some were ordered separately. The ED stated the bed rails remained on the beds at all times and if nursing staff wanted them removed, the ED expected nursing staff to notify them with a work order for removal.

Observation of R3's bed with the director of nursing (DON) on 6/27/19 at 4:30 p.m., identified bed rails in use on both sides of the head of R3's bed. The bed rails were quarter rails and had a parallelogram shape. The rail measurements within the perimeter of the bed rail were 4 inches apart vertically and 6 inches horizontally. The bed was observed to be controlled electronically by a control panel on the footboard side of the bed rail. The DON identified the bed rails were in use to enable staff to adjust the bed, and verified as such, no safety assessment, consent, or physician orders had been obtained prior to placing the side rail into use.

During interview with the DON on 6/27/19 at 4:40 p.m., the DON verified R2 and R3's bed rails had not been assessed for safe use prior to placing them on the residents' beds. The DON stated physical therapy (PT) did not evaluate bed rail use, and they had not obtained physician orders for use. Further, the DON stated after R2's fall, maintenance had not been notified, and had not conducted an inspection of the bed rails to ensure they were securely fit to the bed. The DON stated she'd been updated about R2's incident and had reviewed the Incident Report

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with the interdisciplinary team (IDT) on 6/14/19. The DON reviewed R2's EMR and post fall documentation and was unable to verify R2's bed rail was assessed for safety, and appropriateness of use. The DON stated NA-C was a newly hired employee in the faciltiy an had received orientation to safe resident handling, however verified safe resident handling did not include bed mobility.

LPN-B was interviewed on 6/28/19 at 9:35 a.m., and stated when they initiated the quarter bed rails for resident use, the floor nurse was suppose to complete a sit/stand assessment or a transfer and positioning assessment, document in the computer and communicate the information to the nurse manager and DON. LPN-B stated she thought the request was then reviewed by the IDT. She further stated injuries involving equipment were documented on an internal incident report, and communicated to the DON, administrator, nurse manager, family, and providers. The nurse managers and DON would then review any incident reports with the IDT team to identify concerns, update care plans, and provide education when needed. Changes in resident care plans were communicated to NAs during shift report and through verbal communication, and NAs had access to care plans via the facility's electronic documentation system. LPN-B also stated when grab bars were identified to be appropriate, providers were contacted to request a physical therapy (PT) order to assess needs. LPN-B stated the facility did not complete routine bed rail safety monitoring because the facility only used quarter rails, grab bars which were always on the beds. She stated they were not routinely removed from

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a bed when a resident was discharged and acknowledged when a resident was admitted, if the bed rails were still on the bed, they usually remained there.

Upon observation of R1's quarter bed rail with the DON on 6/28/19 at 3:39 p.m., the bed rail dimensions were the same as those of the quarter rails on R2's bed: The measurements between the bars within the perimeter were 4 1/2 inches vertically by 6 inches horizontally within the area of the bar toward the head of the bed, and 4 1/2 inches vertically and 12.5 inches horizontally within the perimeter area toward the footboard. The quarter rails were connected to the bed frame at a single point and had a vertical gap 18 inches from the bed frame at the point of attachment. The grab bar was loose when pressure was applied to the ends of the rails.

Manufacturer information for the beds and bed rails were requested however, no manufacturer information was provided.

On 6/28/19, at 10:30 a.m., the DON confirmed a total of 43 of 58 residents used some type of bed rail in the facilty. None of the bed rails were evaluated for safety prior to use and no bed rails were monitored for safety during use. Additionally, no physician orders were obtained for use of side rails, and no consents were obtained from residents or resident representatives for use of bed rails.

Interview with the medical director (MD) on on 6/28/19, at 11:10 a.m., identified her expectation for bed rails was for the facilty to contact physical therapy or occupational therapy to evaluate

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residents' need for using a bed rail to ensure residents were truly be able to be able to assist in movement before putting bed rails into use. She expected the facilty to obtain an order for PT or OT to evaluate any bed rail to assess for use and safety before putting them into use.

Review of the facility's 5/17, Bed Safety Policy indicated bed rail usage would occur only when medically necessary, as documented by the provider, and when the total bed environment (bed frame, mattress, bed, rails, and overlays) were inspected and verified to be free of entrapment risk. The policy also indicated annual inspections of bedframes, mattresses and bed rails (side rails, assist bars, and transfer devices) were indicated to identify and eliminate any potential entrapment issues, and to ensure bed rails were compatible with the bed frame and mattress. The policy indicated these inspections were to be documented. The facilty was to consider whether an alternative to side rails could be used. Assessments were to include, but were not limited to, the use of the Physical Device and Restraint Assessment, Section G of the MDS, and input from the physical therapist and restorative nurse. A bed inspection kit was available from the Good Samaritan National Campus Resource Library, and an on line focus audit was available for bed and safety use. Mattresses were inspected for movement on the platform. Movement of several inches constituted a safety hazard. In instances where a gap between the mattress and headboard, footboard, or side rail was greater than 4 inches, a gap guard to reduce the gap was a temporary, acceptable use until a suitable mattress was obtained. Residents with medically necessary

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F 700	Continued From page 20 bed rails were to have bed rails placed in beds of the same manufacturer as the bed and installed according to the manufacturer's directions. No more than 4 inches between the bottom side of the bed rail and tip of the mattress then the rail was in the up position was allowed. Bed rail bars were also not to be more than four inches apart. When an appropriate order was received for bed rails, only quarter rails were to be used. A policy and procedure was requested for maintenance of equipment. No policy was provided. The Guidance for Industry and FDA (Federal Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment manual dated 3/10/06, identified Zone 1 as the area, "any open space within the perimeter of the rail". It also noted HBSW [Hospital Bed Safety Workgroup] and IEC [International Electrotechnical Commission] recommend the space be less than 4 3/4 inches.	F 700		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 19, 2019

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

Re: State Nursing Home Licensing Orders - Complaint Number H5207042C

Dear Administrator:

A complaint investigation was completed on June 28, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00903	A. BUILDING: _____ B. WING _____	C 06/28/2019

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GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/26, 6/27 and 6/28/19, an abbreviated survey was conducted to determine compliance with State licensure. Complaint H5207042C was substantiated. The following correction orders are issued. The facility is enrolled in ePOC and therefore a	2 000		

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2 000	Continued From page 1 signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions identified to prevent falls were implemented for 1 of 1 resident (R1), and failed to ensure the safe use of grab bars/bed rails to minimize the risk of accidents 3 of 3 resident (R2, R3, R1). Findings include: R2's face sheet identified diagnoses including: dementia, depression, anxiety disorder, kidney disorder, history of stroke with right side hemiplegia and hemiparesis, and history of falls.	2 830	1. R1, R2, & R3□s care plans have been reviewed after assessments completed for appropriate need for assist bars. 2. Care plans for all residents in the building have been reviewed and updated to reflect appropriate need for assist bars after completion of assessments. Assessments will be completed upon admission, re-admission, annually, quarterly, with significant change in condition per the RAI manual guidelines and prn going forward to ensure continued use is safe and appropriate.	7/29/19

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2 830	Continued From page 2 R2's annual Minimum Data Set (MDS) assessment dated 5/3/19, indicated R2 had moderately impaired cognition and required extensive assistance of 2 staff for bed mobility, dressing, toileting, and total dependence of 2 staff for transfers.The MDS did not identify R2 used bed rails for bed mobility. During an interview with family member (FM)-A on 6/26/19, at 3:05 p.m., FM-A acknowledged visiting R2 at least 5 days per week. FM-A reported R2 had experienced a fall from his bed on 6/13/19 at 5:50 a.m. while receiving care. FM-A stated R2 had moderate confusion, and could not remember details of his fall but stated after the fall, R2 developed a hematoma on the underside of his right elbow. In addition, FM-A said R2's arm turned dark, blackish-purple from the mid upper arm to the hand. FM-A displayed a picture of R2's arm on her cell phone. The image of R2's right arm depicted dark, blackish-purple discoloration extending from R2's mid upper arm to the hand. FM-A further stated R2 required an x-ray of his arm, but no fracture was identified. FM-A stated since the fall, R2 had experienced an increase in pain in the right arm, had stopped feeding himself, now requiring total assistance of 1 staff to eat and drink. FM-A stated R2 had experienced a gradual decline in his health prior to his fall out of bed, and FM-A stated R2 was "giving up." An Incident Report dated 6/13/19, indicated R2 had rolled over in bed while one nursing assistant, (NA)-D, was providing care to change R2's incontinence brief. The report indicated while turning to his side, R2 had attempted to grab the bed rail and missed, rolling out of bed onto the floor. According to the report, licensed	2 830	Care plans to be updated with changes prn. 3. All Licensed nurses will be educated on the correct policy and procedure for implementing assist bars and notifying Environmental Services of concerns with equipment. 4. Audits will be conducted by DNS or designee via observation and chart review to ensure appropriate use of assist bars and to ensure appropriate assessments are completed prior to implementation of assist bars as well as updated care plans. These audits will be completed on 5 random residents and be completed weekly x4, then monthly x2. Results will be taken to the QAPI committee monthly meeting for review and further recommendations.	

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2 830	Continued From page 3 practical nurse (LPN)-A had arrived to the room and found R2 sitting on the floor facing the door with his legs underneath him, and his left arm was caught between the mattress and grab rail attached to the bed. The report indicated R2 sustained a small skin tear on his upper right chest, and was unable to report how he fell from bed. Although requested, no post fall investigative documentation was provided. R2's progress note on 6/14/19, identified R2's fall was reviewed by the interdisciplinary team. (IDT). The nurse manager was delegated to observe and assess R2's turning needs. There was no documentation of such assessment having been conducted. Observation of R2's bed on 6/26/19 at 3:20 p.m., identified quarter bed rails were in place on R2's bed. The measurements between the bars within the perimeter were 4 1/2 inches vertically by 6 inches horizontally within the area of the bar toward the head of the bed, and 4 1/2 inches vertically and 12.5 inches horizontally within the perimeter area toward the footboard. The quarter rails were connected to the bed frame at a single point and had a vertical gap 18 inches from the bed frame at the point of attachment. The grab bar was loose when pressure was applied to the ends of the rails. R2's bed also had a gap guard at the foot of the bed to keep the mattress snug on the bed frame. R2's care plan identified R2 used assist bars for bed mobility and required total assistance of 2 staff to turn to side. The care plan further indicated R2 required extensive assist of 2 staff for personal cares and repositioning.	2 830		

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2 830	Continued From page 4 R2's current physician orders did not include an order for bed rails, and the medical record did not include documentation R2 and/or R2's representative had been provided sufficient information about risks and benefits so an informed decision could be made about the use of the rails. A Positioning Assessment and Evaluation dated 5/10/19, identified R2 was dependent on staff for transfers and repositioning. The assessment indicated R2 was able to hold onto the grab bar when on his side, and indicated R2 had multiple diagnoses affecting positioning including hemiparesis and vascular dementia. The assessment noted R2 had right sided weakness in his hand, arm and leg, but his left arm was strong. R2 was identified as alert, oriented to person, place and time, and could communicate and follow commands. During interview with licensed practical nurse (LPN)-A on 6/28/19 at 7:56 a.m., LPN-A stated she was the nurse who had responded to R2's fall, but was not present during the fall. LPN-A said when she'd entered the room, R2 was sitting on the floor facing the door, with his arm on the bed partially wedged between the mattress and the bed rail. LPN-A said she had gently released the R2's arm and stated he was able to assist her. LPN-A stated although R2's neurological status was assessed as normal at that time, he was unable to explain what happened. LPN-A stated NA-C, the only staff in the room at the time of the fall, had reported R2 had not hit his head during the fall, but had reached for the grab rail, missed and rolled out of bed. LPN-A verified R2 had sustained a skin tear on his right chest, but stated she hadn't measured it. An incident report	2 830		

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2 830	Continued From page 5 and fall report were completed following the fall. Family, the physician, director of nursing (DON) and nurse manager were notified. However, LPN-A stated she had not notified maintenance of R2's arm getting caught between the grab bar and mattress, and had not completed a repair request for the side rail to have it checked for safety. LPN-A further stated when residents were assessed for side rails, staff looked at them to see if they could get out of bed and if the resident needed side rails, they communicated with the day shift to notify the nurse manger. LPN-A was unaware of any other facility process for bed rail safety assessments, and stated since the facility only used grab bars, they had not felt assessments were required. An attempt was made on 6/27/19 at 3:00 p.m., to interview NA-C without any response. At that time the DON was asked to have NA-C contact the surveyor. However, the DON stated NA-C was on vacation until the following week. During interview with the environmental services director (ED) on 6/27/19, at 12:35 p.m., he verified the measurements of the quarter rails but stated he was unsure whether they met safety recommendations to prevent resident entrapment. ED stated he was unaware R2's arm had been trapped between the bed rail and mattress following the fall on 6/13/19, and was unsure whether the bed rail had been checked for safety after the fall. ED stated the facility had utilized many types of bed rails on the beds,and was unsure of the facility process to determine whether a bed rail met safety requirements for resident use. ED also confirmed there was no routine audit/safety checks conducted by environmental services staff to verify the bed rails	2 830		

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2 830	Continued From page 6 were maintained in safe working order. He was unsure who was responsible for monitoring resident equipment for safety but stated the nursing staff notified the maintenance department by email, or with written repair requests, to add, remove or repair resident equipment. At that time, the ED observation of R2's bed rails with the surveyor and the ED agreed R2's bed rails had some "play," which he identified as "normal". At 1:30 p.m. on 6/27/19, the ED confirmed there was no policy or procedure in place to identify when bed rails should be inspected for resident safety and stated there was no maintenance schedule for maintaining bed rails, bed frames, and mattresses. If maintenance was required for an in use bed rail, the nursing department was expected to complete a repair request either on a written document or sent by email. In addition, the ED stated bed rails were not inspected by his department for compatibility with bed frames, and were not reviewed for fit. The ED was not able to locate the manufacturer information for the beds or quarter side rails, again stating the facility used several different types of bed rails: Some bed rails came with the beds, and some were ordered separately. The ED stated the bed rails remained on the beds at all times and if nursing staff wanted them removed, the ED expected nursing staff to notify them with a work order for removal. Observation of R3's bed with the director of nursing (DON) on 6/27/19 at 4:30 p.m., identified bed rails in use on both sides of the head of R3's bed. The bed rails were quarter rails and had a parallelogram shape. The rail measurements within the perimeter of the bed rail were 4 inches apart vertically and 6 inches horizontally. The	2 830		

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2 830	Continued From page 7 bed was observed to be controlled electronically by a control panel on the footboard side of the bed rail. The DON identified the bed rails were in use to enable staff to adjust the bed, and verified as such, no safety assessment, consent, or physician orders had been obtained prior to placing the side rail into use. During interview with the DON on 6/27/19 at 4:40 p.m., the DON verified R2 and R3's quarter bed rails had not been assessed for safe use prior to placing them on the residents' beds. The DON stated physical therapy (PT) did not evaluate bed rail use, and they had not obtained physician orders for use. Further, the DON stated after R2's fall, maintenance had not been notified, and had not conducted an inspection of the bed rails to ensure they were securely fit to the bed. The DON stated she'd been updated about R2's incident and had reviewed the Incident Report with the interdisciplinary team (IDT) on 6/14/19. The DON reviewed R2's electronic medical record and post fall documentation and was unable to verify R2's bed rail was assessed for safety, and appropriateness of use. The DON stated NA-C was a newly hired employee in the facility an had received orientation to safe resident handling, however verified safe resident handling did not include bed mobility. LPN-B was interviewed on 6/28/19 at 9:35 a.m., and stated when they initiated the quarter bed rails for resident use, the floor nurse was suppose to complete a sit/stand assessment or a transfer and positioning assessment, document in the computer and communicate the information to the nurse manager and DON. LPN-B stated she thought the request was then reviewed by the IDT. She further stated injuries	2 830		

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2 830	Continued From page 8 involving equipment were documented on an internal incident report, and communicated to the DON, administrator, nurse manager, family, and providers. The nurse managers and DON would then review any incident reports with the IDT team to identify concerns, update care plans, and provide education when needed. Changes in resident care plans were communicated to NAs during shift report and through verbal communication, and NAs had access to care plans via the facility's electronic documentation system. LPN-B also stated when grab bars were identified to be appropriate, providers were contacted to request a physical therapy (PT) order to assess needs. LPN-B stated the facility did not complete routine bed rail safety monitoring because the facility only used quarter rails, grab bars which were always on the beds. She stated they were not routinely removed from a bed when a resident was discharged and acknowledged when a resident was admitted, if the bed rails were still on the bed, they usually remained there. Upon observation of R1's quarter bed rail with the DON on 6/28/19 at 3:39 p.m., the bed rail dimensions were the same as those of the quarter rails on R2's bed: The measurements between the bars within the perimeter were 4 1/2 inches vertically by 6 inches horizontally within the area of the bar toward the head of the bed, and 4 1/2 inches vertically and 12.5 inches horizontally within the perimeter area toward the footboard. The quarter rails were connected to the bed frame at a single point and had a vertical gap 18 inches from the bed frame at the point of attachment. The grab bar was loose when pressure was applied to the ends of the rails.	2 830		

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2 830	Continued From page 9 Interview with the medical director (MD) on on 6/28/19, at 11:10 a.m., identified her expectation for bed rails was for the facility to contact physical therapy or occupational therapy to evaluate residents' need for using a bed rail to ensure residents were truly be able to be able to assist in movement before putting bed rails into use. She expected the facility to obtain an order for PT or OT to evaluate any bed rail to assess for use and safety before putting them into use. Review of the facility's 5/17, Bed Safety Policy indicated bed rail usage would occur only when medically necessary, as documented by the provider, and when the total bed environment (bed frame, mattress, bed, rails, and overlays) were inspected and verified to be free of entrapment risk. The policy also indicated annual inspections of bed frames, mattresses and bed rails (side rails, assist bars, and transfer devices) were indicated to identify and eliminate any potential entrapment issues, and to ensure bed rails were compatible with the bed frame and mattress. The policy indicated these inspections were to be documented. The facility was to consider whether an alternative to side rails could be used. Assessments were to include, but were not limited to, the use of the Physical Device and Restraint Assessment, Section G of the MDS, and input from the physical therapist and restorative nurse. A bed inspection kit was available from the Good Samaritan National Campus Resource Library, and an on line focus audit was available for bed and safety use. Mattresses were inspected for movement on the platform. Movement of several inches constituted a safety hazard. In instances where a gap between the mattress and headboard, footboard, or side rail was greater than 4 inches,	2 830		

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2 830	Continued From page 10 a gap guard to reduce the gap was a temporary, acceptable use until a suitable mattress was obtained. Residents with medically necessary bed rails were to have bed rails placed in beds of the same manufacturer as the bed and installed according to the manufacturer's directions. No more than 4 inches between the bottom side of the bed rail and tip of the mattress then the rail was in the up position was allowed. Bed rail bars were also not to be more than four inches apart. When an appropriate order was received for bed rails, only quarter rails were to be used. A policy and procedure was requested for maintenance of equipment. No policy was provided. The Guidance for Industry and FDA (Federal Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment manual dated 3/10/06, identified Zone 1 as the area, "any open space within the perimeter of the rail". It also noted HBSW [Hospital Bed Safety Workgroup] and IEC [International Electrotechnical Commission] recommend the space be less than 4 3/4 inches. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to bedrails, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.	2 830		

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2 830	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately assess, and obtain consent for the use of bedrails for 3 of 3 residents (R2, R3 and R1) reviewed who utilized quarter side rails for assistance with bed mobility, and failed to ensure the bed rails fit the bed appropriately and were used in accordance with FDA and manufacturer guidance. Findings include: During an interview with family member (FM)-A on 6/26/19, at 3:05 p.m., FM-A acknowledged visiting R2 at least 5 days per week. FM-A reported R2 had experienced a fall from his bed on 6/13/19 at 5:50 a.m. while receiving care. FM-A stated R2 had moderate confusion, and could not remember details of his fall but stated after the fall, R2 developed a hematoma on the underside of his right elbow. In addition, FM-A said R2's arm turned dark, blackish-purple from	21685	1. R1, R2, and R3□s quarter rails have been removed from their beds. R1, R2, R3 have been re-assessed for the need of an assist bar. All other residents with quarter rails have had rails removed and have been re-assessed for the need of an assist bar. All care plans have been updated appropriately. 2. All residents in the building will be assessed for appropriate need of assist bars. Bed inspections will be completed on new equipment before putting into circulation and prn with equipment changes. 3. All facility beds have bed tested using the bed inspection kit. Results will be stored by the Environmental Service Director. All Licensed nurses will be	7/29/19

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21685	Continued From page 12 the mid upper arm to the hand. FM-A displayed a picture of R2's arm on her cell phone. The image of R2's right arm depicted dark, blackish-purple discoloration extending from R2's mid upper arm to the hand. FM-A further stated R2 required an x-ray of his arm, but no fracture was identified. FM-A stated since the fall, R2 had experienced an increase in pain in the right arm, had stopped feeding himself, now requiring total assistance of 1 staff to eat and drink. FM-A stated R2 had experienced a gradual decline in his health prior to his fall out of bed, and FM-A stated R2 was "giving up." An Incident Report dated 6/13/19, indicated R2 had rolled over in bed while one nursing assistant, (NA)-D, was providing care to change R2's incontinence brief. The report indicate while turning to his side, R2 had attempted to grab the bed rail and missed, rolling out of bed onto the floor. According to the report, licensed practical nurse (LPN)-A had arrived to the room and found R2 sitting on the floor facing the door with his legs underneath him, and his left arm was entrapped between the mattress and half rail attached to the bed. The report indicated R2 sustained a small skin tear on his upper right chest, and was unable to report how he fell from bed. Although requested, no post fall investigative documentation was provided. R2's progress note on 6/14/19, identified R2's fall was reviewed by the interdisciplinary team. (IDT). The nurse manager was delegated to observe and assess R2's turning needs. There was no documentation of such assessment having been conducted. R2's face sheet identified diagnoses including:	21685	educated on the correct policy and procedure for implementing assist bars and notifying Environmental Services of concerns with equipment. 4. Bed Assessment and Side Rail Safety Audit will be completed by Environmental Services Director or designee via observation and chart reviews to ensure assist bars fit the bed appropriately and are used per policy and procedure. These audits will be completed weekly x4, then monthly x2. Results will be taken to the QAPI committee monthly meeting for review and further recommendation.	

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21685	Continued From page 13 dementia, depression, anxiety disorder, kidney disorder, history of stroke with right side hemiplegia and hemiparesis, and history of falls. R2's annual Minimum Data Set (MDS) assessment dated 5/3/19, indicated R2 had moderately impaired cognition and required extensive assistance of 2 staff for bed mobility, dressing, toileting, and total dependence of 2 staff for transfers. The MDS indicated R2 had been able to eat independently after staff assisted with setting up his meals. The MDS did not identify R2 used bed rails for bed mobility. Observation of R2's bed on 6/26/19 at 3:20 p.m., identified quarter bed rails were in place on R2's bed. The measurements between the bars within the perimeter were 4 1/2 inches vertically by 6 inches horizontally within the area of the bar toward the head of the bed, and 4 1/2 inches vertically and 12.5 inches horizontally within the perimeter area toward the footboard. The quarter rails were connected to the bed frame at a single point and had a vertical gap 18 inches from the bed frame at the point of attachment. The grab bar was loose when pressure was applied to the ends of the rails. R2's bed also had a gap guard at the foot of the bed to keep the mattress snug on the bed frame. R2's current physician orders did not include an order for bed rails, and the medical record did not include documentation R2 and/or R2's representative had been provided sufficient information about risks and benefits so an informed decision could be made about the use of the rails. A Positioning Assessment and Evaluation dated	21685		

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21685	Continued From page 14 5/10/19, identified R2 was dependent on staff for transfers and repositioning. The assessment indicated R2 was able to hold onto the grab bar when on his side, and indicated R2 had multiple diagnoses affecting positioning including hemiparesis and vascular dementia. The assessment noted R2 had right sided weakness in his hand, arm and leg, but his left arm was strong. R2 was identified as alert, oriented to person, place and time, and could communicate and follow commands. During interview with licensed practical nurse (LPN)-A on 6/28/19 at 7:56 a.m., LPN-A stated she was the nurse who had responded to R2's fall, but was not present during the fall. LPN-A said when she'd entered the room, R2 was sitting on the floor facing the door, with his arm on the bed partially wedged between the mattress and the bed rail. LPN-A said she had gently released the R2's arm and stated he was able to assist her. LPN-A stated although R2's neurological status was assessed as normal at that time, he was unable to explain what happened. LPN-A stated NA-C, the only staff in the room at the time of the fall, had reported R2 had not hit his head during the fall, but had reached for the grab rail, missed and rolled out of bed. LPN-A verified R2 had sustained a skin tear on his right chest, but stated she hadn't measured it. An incident report and fall report were completed following the fall. Family, the physician, director of nursing (DON) and nurse manager were notified. However, LPN-A stated she had not notified maintenance of R2's arm getting caught between the grab bar and mattress, and had not completed a repair request for the side rail to have it checked for safety. LPN-A further stated when residents were assessed for side rails, staff looked at them	21685		

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21685	Continued From page 15 to see if they could get out of bed and if the resident needed side rails, they communicated with the day shift to notify the nurse manger. LPN-A was unaware of any other facility process for bedrail safety assessments, and stated since the facilty only used grab bars, they had not felt assessments were required. An attempt was made on 6/27/19 at 3:00 p.m., to interview NA-C without any response. At that time the DON was asked to have NA-C contact the surveyor. However, the DON stated NA-C was on vacation until the following week. During interview with the environmental services director (ED) on 6/27/19, at 12:35 p.m., he verified the measurements of the bed rails but stated he was unsure whether the quarter bed rails met safety recommendations to prevent resident entrapment. ED stated he was unaware R2's arm had been trapped between the bed rail and mattress following the fall on 6/13/19, and was unsure whether the bed rail had been checked for safety after the fall. ED stated the facilty had utilized many types of bed rails on the beds,and was unsure of the facility process to determine whether a bed rail met safety requirements for resident use. ED also confirmed there was no routine audit/safety checks conducted by environmental services staff to verify the bed rails were maintained in safe working order. He was unsure who was responsible for monitoring resident equipment for safety but stated the nursing staff notified the maintenance department by email, or with written repair requests, to add, remove or repair resident equipment. At that time, the ED observation of R2's bed rails with the surveyor and the ED agreed R2's bed rails had some "play," which he	21685		

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21685	Continued From page 16 identified as "normal". At 1:30 p.m. on 6/27/19, the ED confirmed there was no policy or procedure in place to identify when bed rails should be inspected for resident safety and stated there was no maintenance schedule for maintaining bed rails, bed frames, and mattresses. If maintenance was required for an in use bed rail, the nursing department was expected to complete a repair request either on a written document or sent by email. In addition, the ED stated bed rails were not inspected by his department for compatibility with bed frames, and were not reviewed for fit. The ED was not able to locate the manufacturer information for the beds or quarter side rails, again stating the faciltiy used several different types of bed rails: Some bed rails came with the beds, and some were ordered separately. The ED stated the bed rails remained on the beds at all times and if nursing staff wanted them removed, the ED expected nursing staff to notify them with a work order for removal. Observation of R3's bed with the director of nursing (DON) on 6/27/19 at 4:30 p.m., identified bed rails in use on both sides of the head of R3's bed. The bed rails were quarter rails and had a parallelogram shape. The rail measurements within the perimeter of the bed rail were 4 inches apart vertically and 6 inches horizontally. The bed was observed to be controlled electronically by a control panel on the footboard side of the bed rail. The DON identified the bed rails were in use to enable staff to adjust the bed, and verified as such, no safety assessment, consent, or physician orders had been obtained prior to placing the side rail into use.	21685		

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21685	Continued From page 17 During interview with the DON on 6/27/19 at 4:40 p.m., the DON verified R2 and R3's bed rails had not been assessed for safe use prior to placing them on the residents' beds. The DON stated physical therapy (PT) did not evaluate bed rail use, and they had not obtained physician orders for use. Further, the DON stated after R2's fall, maintenance had not been notified, and had not conducted an inspection of the bed rails to ensure they were securely fit to the bed. The DON stated she'd been updated about R2's incident and had reviewed the Incident Report with the interdisciplinary team (IDT) on 6/14/19. The DON reviewed R2's EMR and post fall documentation and was unable to verify R2's bed rail was assessed for safety, and appropriateness of use. The DON stated NA-C was a newly hired employee in the faciltiy an had received orientation to safe resident handling, however verified safe resident handling did not include bed mobility. LPN-B was interviewed on 6/28/19 at 9:35 a.m., and stated when they initiated the quarter bed rails for resident use, the floor nurse was suppose to complete a sit/stand assessment or a transfer and positioning assessment, document in the computer and communicate the information to the nurse manager and DON. LPN-B stated she thought the request was then reviewed by the IDT. She further stated injuries involving equipment were documented on an internal incident report, and communicated to the DON, administrator, nurse manager, family, and providers. The nurse managers and DON would then review any incident reports with the IDT team to identify concerns, update care plans, and provide education when needed. Changes in resident care plans were communicated to NAs	21685		

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21685	Continued From page 18	21685		

during shift report and through verbal communication, and NAs had access to care plans via the facility's electronic documentation system. LPN-B also stated when grab bars were identified to be appropriate, providers were contacted to request a physical therapy (PT) order to assess needs. LPN-B stated the facility did not complete routine bed rail safety monitoring because the facility only used quarter rails, grab bars which were always on the beds. She stated they were not routinely removed from a bed when a resident was discharged and acknowledged when a resident was admitted, if the bed rails were still on the bed, they usually remained there.

Upon observation of R1's quarter bed rail with the DON on 6/28/19 at 3:39 p.m., the bed rail dimensions were the same as those of the quarter rails on R2's bed: The measurements between the bars within the perimeter were 4 1/2 inches vertically by 6 inches horizontally within the area of the bar toward the head of the bed, and 4 1/2 inches vertically and 12.5 inches horizontally within the perimeter area toward the footboard. The quarter rails were connected to the bed frame at a single point and had a vertical gap 18 inches from the bed frame at the point of attachment. The grab bar was loose when pressure was applied to the ends of the rails.

Manufacturer information for the beds and bed rails were requested however, no manufacturer information was provided.

On 6/28/19, at 10:30 a.m., the DON confirmed a total of 43 of 58 residents used some type of bed rail in the facilty. None of the bed rails were evaluated for safety prior to use and no bed rails

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21685	Continued From page 19 were monitored for safety during use. Additionally, no physician orders were obtained for use of side rails, and no consents were obtained from residents or resident representatives for use of bed rails. Interview with the medical director (MD) on on 6/28/19, at 11:10 a.m., identified her expectation for bed rails was for the facilty to contact physical therapy or occupational therapy to evaluate residents' need for using a bed rail to ensure residents were truly be able to be able to assist in movement before putting bed rails into use. She expected the facilty to obtain an order for PT or OT to evaluate any bed rail to assess for use and safety before putting them into use. Review of the facility's 5/17, Bed Safety Policy indicated bed rail usage would occur only when medically necessary, as documented by the provider, and when the total bed environment (bed frame, mattress, bed, rails, and overlays) were inspected and verified to be free of entrapment risk. The policy also indicated annual inspections of bedframes, mattresses and bed rails (side rails, assist bars, and transfer devices) were indicated to identify and eliminate any potential entrapment issues, and to ensure bed rails were compatible with the bed frame and mattress. The policy indicated these inspections were to be documented. The facilty was to consider whether an alternative to side rails could be used. Assessments were to include, but were not limited to, the use of the Physical Device and Restraint Assessment, Section G of the MDS, and input from the physical therapist and restorative nurse. A bed inspection kit was available from the Good Samaritan National Campus Resource Library, and an on line focus	21685		

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21685	Continued From page 20 audit was available for bed and safety use. Mattresses were inspected for movement on the platform. Movement of several inches constituted a safety hazard. In instances where a gap between the mattress and headboard, footboard, or side rail was greater than 4 inches, a gap guard to reduce the gap was a temporary, acceptable use until a suitable mattress was obtained. Residents with medically necessary bed rails were to have bed rails placed in beds of the same manufacturer as the bed and installed according to the manufacturer's directions. No more than 4 inches between the bottom side of the bed rail and tip of the mattress then the rail was in the up position was allowed. Bed rail bars were also not to be more than four inches apart. When an appropriate order was received for bed rails, only quarter rails were to be used. A policy and procedure was requested for maintenance of equipment. No policy was provided. The Guidance for Industry and FDA (Federal Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment manual dated 3/10/06, identified Zone 1 as the area, "any open space within the perimeter of the rail". It also noted HBSW [Hospital Bed Safety Workgroup] and IEC [International Electrotechnical Commission] recommend the space be less than 4 3/4 inches. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to maintain resident equipment in a safe manner. The facility could create policies and procedures, educate	21685		

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21685	Continued From page 21 staff on these perform environmental rounds/audits periodically to ensure equipment was maintained, and could report findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		