Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL23761016M
Compliance #: HL23761017C

Date Concluded: December 5, 2019

Name, Address, and County of Licensee Investigated:
Sunlight Services, LLC
440 Virginia Street
St. Paul, MN 55103
Ramsey County

Facility Type: Home Care Provider

Investigator's Name:
Jess Gallmeier, RN, BSN, PHN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The facility abused the client when the client was physically restrained while in bed and in the wheelchair.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility was responsible for the maltreatment. The client was unreasonably confined to a wheelchair when multiple facility staff members restrained the client using a lap seatbelt across her waist and a transfer belt (a belt wrapped around a person's waist to aid in mobility) affixed to the wheelchair and secured across her torso. The client was unreasonably confined to her bed when multiple facility staff members restrained the client by using two grab bars and two bedside rails in the up position at all times. The restraints were used to keep the client from moving around, remaining in bed, and falling.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The client and the client's family member were interviewed.

The client's entire medical record was reviewed, including hospice records. The investigator observed staff members assisting clients with medication administration, meals, mobility and hygiene cares. The investigation included review of facility policies, procedures and incident reports.

The client's diagnoses included a medical diagnosis affecting cognition, insomnia, and history of a cerebrovascular accident (a stroke). The client's service plan directed staff members to assist the client with medication management, bathing, grooming, dressing, toileting, transfers, behavior management, meals, housekeeping, and laundry services.

One morning, the client was observed lying in bed in her room. The client's hospital bed was positioned in the corner of the room. The head of the client's bed was against one wall, and the left side of the client's bed was against another wall. The client was lying on her back, with her head near the foot of the bed. Two silver metal bed side rails were attached to the bedframe bilaterally in the lower third of the bed (because the client was positioned upside down in bed, the client's head was near the bed side rails). Two white metal grab bars were attached to the bedframe bilaterally near the head of the bed (because the client was positioned upside down in bed, the client's feet were near the grab bars). All bed side rails and grab bars were in the up position.

At that same time, the client's wheelchair was also observed sitting in her room with the back against the wall. A black lap seat belt was observed hanging open on either side of the seat and attached to the wheelchair frame. A blue transfer belt (a belt wrapped around a person's waist to aid in mobility) was affixed to the right side of wheelchair back rest and hanging down.

The client's fall record indicated the client fell while alone in the living room. The record stated the client "was belted into her wheelchair and tipped it over on top of her while the aide was helping another resident with clothes in her room."

The client's nursing assessment indicated the client needed assistance with sitting up, turning, repositioning, transferring, and use of a wheelchair. The assessment indicated the client was assessed for a left bed side rail and the indication for use was fall prevention. The assessment also indicated the client had no behaviors that required intervention. Additionally, the assessment indicated the client was agitated at times and required redirection. The assessment did not include the client's bilateral grab bars, right sided lower bed side rail, wheelchair lap seatbelt, or the use of a transfer belt affixed to the wheelchair back rest.

During an interview, a facility staff member indicated the client spent the entire day in bed, except for 2-3 hours in the morning when the client was in the wheelchair. The facility staff member stated when the client was in bed, the grab bars and bed side rails were raised in the up position. The facility staff member indicated the grab bars and bed side rails were used to keep the client in bed and to keep the client from falling. The facility staff member then stated the client did not fall frequently. The facility staff member indicated the client required

assistance with repositioning in bed, transferring from the bed to the wheelchair, and pushing the wheelchair. The facility staff member stated that after the client was placed in the wheelchair, the black lap seatbelt is buckled across her waist. The facility staff member then indicated a bath towel is placed across the client's torso and the blue transfer belt is wrapped from the right side of the client's wheelchair back rest, across the client's torso, over the towel, and buckled together behind the back of the wheelchair back rest. The facility staff member stated the client's arms are secured under the transfer belt, limiting the client's movement. The facility staff member indicated the client moves around a lot while in the wheelchair and the belts are used to keep her in place. The facility staff member stated the use of the grab bars, bed side rails, lap seatbelt, and transfer belt had been going on for a while. The facility staff member indicated she was taught to use the transfer belt on the wheelchair by the facility administrator.

During an interview, the Registered Nurse (RN) indicated the client did not always have four bed side rails on her hospital bed. The RN stated she only assessed the client for a left bed side rail. The RN indicated she was unaware of the use of a transfer belt to keep the client in the wheelchair, however, she had seen the lap seatbelt used. The RN indicated the use of the transfer belt would be a restraint and that it would not be safe. The RN stated that it would not be the place of other staff to determine interventions for changes in client needs and that, as the nurse, she should be notified.

During an interview, the administrator indicated after the client's fall, he called the medical supply company and had additional bed side rails put on. The administrator indicated it was his decision to add additional bed side rails and was not the result of a nursing assessment. The administrator indicated one of the facility staff members had the idea to attach a transfer belt to the client's chair and secure it around her torso to keep her from moving around and falling. The administrator indicated the transfer belt was not being used the day the client tipped her wheelchair on top of herself, but the lap seatbelt was.

In conclusion, abuse was substantiated.

Abuse: Minnesota Statutes section 626.5572, subdivision 2

"Abuse" means:

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: No, interview attempted but unable to be completed due to cognitive level and language barrier.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility stopped using physical restraints with the client.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc: Health Regulation Division – Home Care Assisted Living Program
The Office of Ombudsman for Long-Term Care
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23761	A. BUILDING: _____ B. WING _____	R-C 10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT SERVICES LLC	440 VIRGINIA STREET SAINT PAUL, MN 55103

(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) COMPLETE DATE
{0 000}	Initial Comments On October 24, 2019, the Minnesota Department of Health conducted a licensing order follow-up related to complaint #HL23761010C/#HL23761009M. The following correction order is re-issued for #HL23761010C/#HL23761009M, tag identification 0325, 0805, 0860 immediate orders (ACO Shell ZCTZ12), and 2015. The following correction order is re-issued for #HL23761012C (ACO Shell SBCO12), tag identification 0800.	{0 000}		
{0 325} SS=I	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a client was free from abuse when multiple staff restrained one of three clients (C1) reviewed for maltreatment. C1 was unreasonably confined to a wheelchair when staff restrained C1 using a lap seatbelt across her waist and a transfer belt (a belt wrapped around a person's waist to aid in mobility) affixed to the wheelchair and secured across her torso. C1 was unreasonably confined	{0 325}		

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{0 325}	Continued From page 1 to her bed when multiple staff restrained C1 by using two grab bars and two bedside rails in the up position at all times. The restraints were used to keep C1 from moving around, remaining in bed, and falling. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: During an observation on October 24, 2019, at 10:13 a.m., C1 was observed lying in bed in her room. C1's hospital bed was positioned in the corner of the room. The head of C1's bed was against one wall, and the left side of C1's bed was against another wall. C1 was lying on her back, with her head near the foot of the bed. Two silver metal bed side rails were attached to the bedframe bilaterally in the lower third of the bed (because C1 was positioned upside down in bed, C1's head was near the bed side rails). Two white metal grab bars were attached to the bedframe bilaterally near the head of the bed (because C1 was positioned upside down in bed, C1's feed were near the grab bars). All bed side rails and grab bars were in the up position. During an observation on October 24, 2019, at 10:48 a.m., C1's wheelchair was observed sitting in her room with the back against the wall. A black lap seat belt was observed hanging open	{0 325}		

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{0 325}	Continued From page 2 on either side of the seat and attached to the wheelchair frame. A blue transfer belt was affixed to the right side of wheelchair back rest and hanging down. C1's medical record was reviewed. C1's diagnoses included a medical diagnosis affecting cognition, insomnia, and a history of cerebrovascular accident (also known as a stroke). C1's service plan, dated October 24, 2019, indicated C1 received services from the comprehensive home care provider for assistance with medication management, bathing, grooming, dressing, toileting, transfers, behavior management, meals, housekeeping, and laundry services. A fall report, dated October 4, 2019, indicated C1 "was belted into her wheelchair and tipped it over on top of her while the aide was helping another resident with clothes in her room." The report also indicated C1 was alone in the living room at the time of the fall. A nursing assessment, dated October 8, 2019, listed the reason for assessment as "14 day". The assessment indicated C1 needed assistance with sitting up, turning, repositioning, transferring, and use of a wheelchair. The assessment indicated C1 was assessed for a left bed side rail and the indication for use was fall prevention. The assessment indicated C1 had no behaviors that required intervention. The assessment also indicated C1 was agitated at times and required redirection. The assessment did not include C1's bilateral grab bars, right sided lower bed side rail, wheelchair lap seatbelt, or the use of a transfer belt affixed to the wheelchair back rest.	{0 325}		

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{0 325}	Continued From page 3 During an interview on October 24, 2019 at 11:49 a.m., unlicensed personnel (ULP)-A indicated C1 spent the entire day in bed, except for 2-3 hours in the morning when C1 is in the wheelchair. ULP-A stated when C1 was in bed, the grab bars and bed side rails were raised in the up position. ULP-A indicated the grab bars and bed side rails were used to keep C1 in bed and to keep C1 from falling. ULP-A then stated C1 did not fall frequently. ULP-A indicated C1 required assistance with repositioning in bed, transferring from the bed to the wheelchair, and pushing the wheelchair. ULP-A stated that after C1 was placed in the wheelchair, the black lap seatbelt is buckled across her waist. ULP-A then indicated a bath towel is placed across C1's torso and the blue transfer belt is wrapped from the right side of C1's wheelchair back rest, across C1's torso, over the towel, and buckled together behind the back of the wheelchair back rest. ULP-A stated C1's arms are secured under the transfer belt, limiting C1's movement. ULP-A indicated C1 moves around a lot while in the wheelchair and the belts are used to keep her in place. ULP-A stated the use of the grab bars, bed side rails, lap seatbelt, and transfer belt had been going on for a while. ULP-A indicated she was taught to use the transfer belt on the wheelchair by the Administrator. During an interview on October 24, 2019 at 12:09 p.m., Registered Nurse (RN)-B indicated C1 did not always have four bed side rails on her hospital bed. RN-B stated she only assessed C1 for a left bed side rail. RN-B indicated she was unaware of the use of a transfer belt to keep C1 in the wheelchair, however, she had seen the lap seatbelt used. RN-B indicated the use of the transfer belt would be a restraint and that it would	{0 325}		

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{0 325}	Continued From page 4 not be safe. RN-B stated that it would not be the place of other staff to determine interventions for changes in client needs and that she should be notified. During an interview on October 24, 2019 at 12:22 p.m., Administrator-C indicated after C1's fall, he called the medical supply company and had additional bed side rails put on. Administrator-C indicated it was his decision to add additional bed side rails and was not the result of a nursing assessment. Administrator-C indicated one of the ULPs at the facility had the idea to attach a transfer belt to C1's chair and secure it around her torso to keep her from moving around and falling. Administrator-C indicated the transfer belt was not being used the day C1 tipped her wheelchair on top of herself, but the lap seatbelt was. A policy, titled Vulnerable Adult Reporting and Investigation Policy, dated September 25, 2017, indicated employees would report any suspected maltreatment and allegations would be investigated by the RN and administrator.	{0 325}		
{0 800} SS=D	144A.479, Subd. 5 Handling of Client's Finances/Property Subd. 5. Handling of client's finances and property. (a) A home care provider may assist clients with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a client's property. A home care provider must provide a client with receipts for all transactions and purchases paid with the client's funds. When receipts are not available, the transaction or purchase must be	{0 800}		

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{0 800}	Continued From page 5 documented. A home care provider must maintain records of all such transactions. (b) A home care provider or staff may not borrow a client's funds or personal or real property, nor in any way convert a client's property to the home care provider's or staff's possession. (c) Nothing in this section precludes a home care provider or staff from accepting gifts of minimal value, or precludes the acceptance of donations or bequests made to a home care provider that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986. This MN Requirement is not met as evidenced by: Reissued under ACO Shell SBCO12, project #H23761012C.	{0 800}		
{0 805} SS=F	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6. Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced	{0 805}		

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{0 805}	Continued From page 6 by: Based on document review and interview, the licensee failed to immediately report an allegation maltreatment to the State Agency for one of three clients (C1) reviewed, when licensee staff physically restrained C1 while in bed and the wheelchair. When C1 was in bed, she was restrained using two grab bars and two bed side rails in the up position at all times. When C1 was in the wheelchair, she was restrained using a lap seatbelt across her waist and a transfer belt (a belt wrapped around a person's waist to aid in mobility) affixed to the wheelchair and secured across her torso. The restraints were used to keep C1 from moving around, remaining in bed, and falling. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: C1's medical record was reviewed. C1's diagnoses included a medical diagnosis affecting cognition, insomnia, and a history of cerebrovascular accident (also known as a stroke). C1's service plan, dated October 24, 2019, indicated C1 received services from the comprehensive home care provider for assistance with medication management, bathing, grooming, dressing, toileting, transfers, behavior management, meals, housekeeping, and laundry services.	{0 805}		

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{0 805}	Continued From page 7 A fall report, dated October 4, 2019, indicated C1 "was belted into her wheelchair and tipped it over on top of her while the aide was helping another resident with clothes in her room." A nursing assessment, dated October 8, 2019, listed the reason for assessment as "14 day". The assessment indicated C1 needed assistance with sitting up, turning, repositioning, transferring, and use of a wheelchair. The assessment indicated C1 was assessed for a left bed side rail and the indication for use was fall prevention. The assessment indicated C1 had no behaviors that required intervention. The assessment also indicated C1 was agitated at times and required redirection. The assessment did not include C1's bilateral grab bars, right sided lower bed side rail, wheelchair lap seatbelt, or the use of a transfer belt affixed to the wheelchair back rest. During an interview on October 24, 2019 at 11:49 a.m., unlicensed personnel (ULP)-A indicated C1 spent the entire day in bed, except for 2-3 hours in the morning when C1 is in the wheelchair. ULP-A stated when C1 was in bed, the grab bars and bed side rails were raised in the up position. ULP-A indicated the grab bars and bed side rails were used to keep C1 in bed and to keep C1 from falling. ULP-A indicated C1 required assistance with repositioning in bed, transferring from the bed to the wheelchair, and pushing the wheelchair. ULP-A stated that after C1 was placed in the wheelchair, the black lap seatbelt is buckled across her waist. ULP-A then indicated a bath towel is placed across C1's torso and the blue transfer belt is wrapped from the right side of C1's wheelchair back rest, across C1's torso, over the towel, and buckled together behind the	{0 805}		

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{0 805}	Continued From page 8 back of the wheelchair back rest. ULP-A stated C1's arms are secured under the transfer belt, limiting C1's movement. ULP-A indicated C1 moves around a lot while in the wheelchair and the belts are used to keep her in place. ULP-A stated the use of the grab bars, bed side rails, lap seatbelt, and transfer belt had been going on for a while. ULP-A indicated she was taught to use the transfer belt on the wheelchair by the Administrator. During an interview on October 24, 2019 at 12:09 p.m., Registered Nurse (RN)-B indicated C1 did not always have four bed side rails on her hospital bed. RN-B stated she only assessed C1 for a left bed side rail. RN-B indicated she was unaware of the use of a transfer belt to keep C1 in the wheelchair, however, she had seen the lap seatbelt used. RN-B indicated the use of the transfer belt would be a restraint and that it would not be safe. A policy, titled Vulnerable Adult Reporting and Investigation Policy, dated September 25, 2017, indicated employees would report any suspected maltreatment and allegations would be investigated by the RN and administrator.	{0 805}		
{0 860} SS=D	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health	{0 860}		

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{0 860}	Continued From page 9 professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Reissued under ACO Shell ZCTZ11 for Immediate correction order. Refer to letter dated October 28, 2019 and State form for the results of 0860.	{0 860}		
{02015} SS=F	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall	{02015}		

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(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) COMPLETE DATE
{02015}	Continued From page 10 immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to	{02015}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23761	A. BUILDING: _____ B. WING _____	R-C 10/24/2019

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{02015}	Continued From page 11 the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to immediately report an allegation maltreatment to the State Agency for one of three clients (C1) reviewed, when licensee staff physically restrained C1 while in bed and the wheelchair. When C1 was in bed, she was restrained using two grab bars and two bed side rails in the up position at all times. When C1 was in the wheelchair, she was restrained using a lap seatbelt across her waist and a transfer belt (a belt wrapped around a person's waist to aid in mobility) affixed to the wheelchair and secured across her torso. The restraints were used to keep C1 from moving around, remaining in bed, and falling. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients).	{02015}		

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{02015}	Continued From page 12 The findings include: C1's medical record was reviewed. C1's diagnoses included a medical diagnosis affecting cognition, insomnia, and a history of cerebrovascular accident (also known as a stroke). C1's service plan, dated October 24, 2019, indicated C1 received services from the comprehensive home care provider for assistance with medication management, bathing, grooming, dressing, toileting, transfers, behavior management, meals, housekeeping, and laundry services. A fall report, dated October 4, 2019, indicated C1 "was belted into her wheelchair and tipped it over on top of her while the aide was helping another resident with clothes in her room." A nursing assessment, dated October 8, 2019, listed the reason for assessment as "14 day". The assessment indicated C1 needed assistance with sitting up, turning, repositioning, transferring, and use of a wheelchair. The assessment indicated C1 was assessed for a left bed side rail and the indication for use was fall prevention. The assessment indicated C1 had no behaviors that required intervention. The assessment also indicated C1 was agitated at times and required redirection. The assessment did not include C1's bilateral grab bars, right sided lower bed side rail, wheelchair lap seatbelt, or the use of a transfer belt affixed to the wheelchair back rest. During an interview on October 24, 2019 at 11:49 a.m., unlicensed personnel (ULP)-A indicated C1 spent the entire day in bed, except for 2-3 hours in the morning when C1 is in the wheelchair.	{02015}		

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{02015}	Continued From page 13 ULP-A stated when C1 was in bed, the grab bars and bed side rails were raised in the up position. ULP-A indicated the grab bars and bed side rails were used to keep C1 in bed and to keep C1 from falling. ULP-A indicated C1 required assistance with repositioning in bed, transferring from the bed to the wheelchair, and pushing the wheelchair. ULP-A stated that after C1 was placed in the wheelchair, the black lap seatbelt is buckled across her waist. ULP-A then indicated a bath towel is placed across C1's torso and the blue transfer belt is wrapped from the right side of C1's wheelchair back rest, across C1's torso, over the towel, and buckled together behind the back of the wheelchair back rest. ULP-A stated C1's arms are secured under the transfer belt, limiting C1's movement. ULP-A indicated C1 moves around a lot while in the wheelchair and the belts are used to keep her in place. ULP-A stated the use of the grab bars, bed side rails, lap seatbelt, and transfer belt had been going on for a while. ULP-A indicated she was taught to use the transfer belt on the wheelchair by the Administrator. During an interview on October 24, 2019 at 12:09 p.m., Registered Nurse (RN)-B indicated C1 did not always have four bed side rails on her hospital bed. RN-B stated she only assessed C1 for a left bed side rail. RN-B indicated she was unaware of the use of a transfer belt to keep C1 in the wheelchair, however, she had seen the lap seatbelt used. RN-B indicated the use of the transfer belt would be a restraint and that it would not be safe. A policy, titled Vulnerable Adult Reporting and Investigation Policy, dated September 25, 2017, indicated employees would report any suspected	{02015}		

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{02015}	Continued From page 14 maltreatment and allegations would be investigated by the RN and administrator.	{02015}		