DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL290184363M
Compliance #: HL290187270C

Date Concluded: February 17, 2023

Name, Address, and County of Licensee Investigated:
Lilydale Senior Living
949 Sibley Memorial Highway
Lilydale, MN 55118
Dakota County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Jessica Sellner, RN, Nurse Investigator
Maerin Renee, RN, Nurse Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
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.

Initial Investigation Allegation(s):
The facility neglected the resident when a bed rail was placed on the resident's bed without appropriate assessment and follow-up. The resident became entangled in the bed rail and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure the residents bed rail was assessed and determined to be safe for the resident. The resident was found deceased entrapped in the bedrail.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, staff training files, facility policy and procedures, and prior facility incidents. In addition, observations were completed of other residents siderails and assessments.

The resident resided in an assisted living facility with diagnoses including Parkinson's disease, history of falls, and recent humerus fracture of the left arm. The resident's service plan included assistance with medication management, showering, laundry, and vital signs.

A facility incident report indicated one morning an unlicensed staff entered the resident's bedroom, "and saw resident's right arm holding the inside grab bar and neck resting on the grab bar. The resident's body was on the floor." The resident was deceased and 911 and the resident's family were contacted. The incident investigation indicated there was a "history of this type of incident," with a "reduction plan in place." The reduction plan included providing total assistance with resident cares, and keeping the residents pendant light within reach, and staff reminding the resident to press it when needed. The report indicated contributing factors to the incident included the resident was resistive to using the pendant for assistance, weakness, Parkinson's disease, and restless leg syndrome.

The resident had a recent fall and a short stay at a transitional care unit (TCU) due to weakness and a need for increased staff assistance. The resident returned to the facility 9 days prior to her death. The side rail assessment completed upon return to the facility from TCU indicated the resident used a "grab bar (bed cane)." The resident had a history of falls out of bed and was at risk if siderails were used. However, there was no individualized assessment to determine if the resident was safe to use the specific siderails that were actually being used on the bed. The description of the device in the assessment was not consistent with the type of device actually installed.

The facility provided manufacture instructions for the siderails that were used on the resident's bed were called "safety glo rails." The manufacture instructions indicated entrapment can occur when there was a gap between the side of the mattress and the assistive handrail. The mattress must be tight against the side rails with no gaps and should be, "checked frequently- at least daily." The facility had no documentation the residents siderail had ever been checked since installation.

When interviewed an unlicensed staff member stated she went into the resident's room early one morning to assist the resident with cares. The staff member stated the resident's body was on the floor, her right arm was between the mattress and the siderail, and the resident's neck "was resting between the glo bar [siderail] and the mattress." The staff member stated the resident was clearly deceased and she was "shaken" when she observed the resident.

When interviewed a facility nurse indicated the resident was readmitted following a stay in TCU following a fall, weakness, and need for increased staff assistance with cares. The resident wouldn't always call for staff assistance and the nurse stated she told the resident the prior day she needed to use her call light to ask for assistance with cares. Prior to the residents return from TCU, the facility maintenance installed a grab bar onto the resident's bed to assist with bed mobility. The nurse stated staff contacted her the morning of the resident's death and she

immediately went to the facility along with other management staff. The nurse stated she observed the resident completely out of bed, her right arm “holding onto grab bar,” and the residents head “was leaning on the siderail.” The nurse stated when the funeral staff came to transport the resident to the funeral home, it took several staff to lift up the mattress to get the residents right arm out from between the mattress and the siderail. The nurse also stated the resident had an alarm clock cord wrapped around the grab bar about 2 or 3 times which had to be untwisted before they could lift up the mattress to get the resident out from between the mattress and the siderail.

During interview another facility nurse stated the morning of the incident staff called her and she immediately went to the facility. The nurse stated the resident was on the floor not breathing, her right arm was inside of the siderail, the “left side of her neck was against the side rail,” and the resident was “face down.” The nurse stated the siderail was so tight to the mattress staff had to lift the mattress off the bed to get the resident out from between the siderail and the mattress. The nurse stated maintenance checked all resident siderails once a month.

The facility was unable to provide any documentation the residents siderails were checked for safety after they were installed.

When interviewed, the resident’s family members stated the morning of the resident’s death they were called to the facility. When they arrived at the facility, they were told they should not go into the room because of “the position” the resident was in. They were told the resident was trapped in the siderail and she had “choked.” The family did not see the resident prior to the funeral home arriving.

When interviewed, the funeral home employee stated when they went to pick the residents body up from the facility it was a “horrific scene.” The resident was half on and half off the bed, and her body was stuck between the siderail and the mattress. The employee stated it took 4 people to get the resident out from between the mattress and the siderail. She stated the resident had indentations on the left side of her neck and cheek from the siderails.

The embalming report indicated the resident had indentations on the left side of her face and neck “from the bar on the hospital bed.”

Photographs and video taken the morning of the resident’s death were reviewed. The resident was observed with the lower half of her body on the floor face down; her upper body and head were elevated by the siderail, and her entire right arm was entrapped between the mattress and the siderail. The resident’s right side of her head was pushed down onto her right shoulder with the left side of the resident’s neck, head, and jaw pushed up tightly against the inside of the siderail. The resident’s left ear was folded over under the siderail. The residents left arm was hanging down in front of her and the residents left hand appeared to be resting under the bed on the metal bed frame.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed side rails assessments for all residents utilizing siderails. A maintenance schedule was implemented to check siderails according to specific manufacture recommendations. Risk vs benefits of siderails were completed, individualized, and reviewed with family and/ or residents.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.
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
If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Medical Examiners
Mendota Heights Law Enforcement

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29018	A. BUILDING: ______ B. WING ______	C 02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILYDALE SENIOR LIVING	949 SIBLEY MEMORIAL HIGHWAY LILYDALE, MN 55118

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0 000	Initial Comments	0 000		

Initial Comments

******ATTENTION******

ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER

In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.

INITIAL COMMENTS:

#HL290187270C/#HL290184363M

On January 20, 2023 to February 13, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 76 residents receiving services under the provider's Assisted Living with Dementia Care license.

The following immediate correction order is issued for #HL290187270C/#HL290184363M, tag identification 2310.

The immediacy was removed on February 13, 2023. Non-compliance remains at a I.

The following correction orders which were not immediate were issued for #HL290187270C/#HL290184363M, tag identification 2360 and 3020.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is 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.

THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.

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0 620 SS=J	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility 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 by: Based on interview and record review, the facility failed to report sufficient data to the common entry point (CEP) regarding an incident which occurred involving one of one residents (R1) with records reviewed. Although the resident was found deceased and entrapped in a siderail, the facility did not report all of the details of the incident and reported the incident as "self neglect." This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1 began receiving services April 29, 2022. R1's diagnoses included Parkinson's disease, high blood pressure, restless leg syndrome, osteoarthritis, and closed fracture of the left humerus. R1's service plan dated December 15, 2022, indicated R1 received services including	0 620		

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medication management, vital signs, showering, laundry, and assistance with transfers.

An incident report dated December 24, 2022, at 6:18 a.m. indicated a staff member went in to R1's room for a scheduled visit and found R1 unresponsive, not breathing, and noted R1's right arm was holding the inside of the grab bar and R1's neck was resting on the grab bar with R1's body on the floor. The staff member immediately contacted the facility nurse, who directed her to notify R1's family and call 911. R1 was pronounced dead upon emergency response personnel arrival at the scene.

During interview on January 20, 2023, at approximately 1:00 p.m. registered nurse (RN)-A stated staff called her the morning of December 24, 2022, regarding R1 and she immediately came into the facility. RN-A stated when the funeral staff came to transport the resident to the funeral home, it took several staff to lift up the mattress to get the residents right arm out from between the mattress and the siderail. The nurse also stated the resident had an alarm clock cord wrapped around the grab bar about 2 or 3 times which had to be untwisted before they could lift up the mattress to get the resident out from between the mattress and the siderail.

During interview on January 20, 2023 at approximately 1:30 p.m. licensed practical nurse (LPN)-B stated the morning of R1's death staff called her and she immediately went to the facility. LPN-B stated the resident was on the floor not breathing, her right arm was inside of the siderail, the "left side of her neck was against the side rail," and the resident was "face down." The nurse stated the siderail was so tight to the mattress staff had to lift the mattress off the bed

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to get the resident out from between the siderail and the mattress.

An embalming report dated December 24, 2022, identified indents noted on R1's face and neck and identified the indents were from the bar of R1's bed.

The facility provided a report to the Minnesota Adult Abuse Reporting Center (MAARC) dated December 24, 2022. The MAARC report indicated self-neglect as the concern. The report indicated staff went to check on R1 and she "was found leaning on the floor" with R1's "left arm stuck in between the bedrail. [Resident] was deceased."
The MAARC report lacked description of the extent of R1's entanglement in the side rail and lacked to account for the possibility of facility neglect.

The facility's policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, dated August 1, 2021, indicated the facility developed individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information.

TIME PERIOD FOR CORRECTION: Two (2) days.

02310 SS=L	144G.91 Subd. 4 (a) Appropriate care and services	02310		

(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care

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standards.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide care and services according to acceptable health care standards, medical, or nursing standards for fifteen of fifteen residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15) who utilized bed rails.

This practice resulted in a level four violation (a violation that results in 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 residents).

This resulted in an immediate order on February 8, 2023.

The immediacy was removed February 13, 2023. Non-compliance remains at scope and severity of I.

The findings include:

R1
R1 began receiving services April 29, 2022. R1's diagnoses included Parkinson's disease, high blood pressure, restless leg syndrome, osteoarthritis, and closed fracture of the left humerus.

R1 re-admitted to the facility on December 15, 2022, following a rehab stay in a Transitional Care Unit (TCU).

R1's service plan dated December 15, 2022,

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indicated R1 received services including medication management, vital signs, showering, laundry, and assistance with transfers.

R1's physician orders sent upon her re-admission to the licensee, dated December 1, 2022, included an order for bilateral grab bars to promote independence with transfers and positioning.

A Side Rail Assessment dated December 15, 2022, and signed December 20, 2022, indicated R1 utilized a grab bar (bed cane) for assistance with transfers and fall prevention. It was not identified which side of the bed the grab bar was on. The assessment indicated the grab bar met FDA measurement guidelines and R1 and family had been provided side rail risk and benefit information.

R1's medical record included a Benefits and Risks of Side Rail document included R1's name hand written on the top and the document was signed December 15, 2022. The documented identified benefits and risks of side rail use. The document was not individualized to R1's needs and did not include information regarding benefits or risks of the use of a grab bar.

R1's record lacked documentation about R1's side rail including:

-Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;

-Risk vs. benefits discussion, individualized to R1's risks;

-R1's preferences;

-Documentation of installation, use, and maintenance according to manufacturer's guidelines;

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-Documentation of physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation;
-Documentation of any necessary information related to interventions to mitigate safety risks;
-Documentation that the bed rails were determined to not act as a restraint;
-Readily accessible manufacturer's bed rail guidelines;

An incident report dated December 24, 2022, at 6:18 a.m. indicated a staff member went in to R1's room for a scheduled visit and found R1 unresponsive, not breathing, and noted R1's right arm was holding the inside of the grab bar and R1's neck was resting on the grab bar with R1's body on the floor. The staff member immediately contacted the facility nurse, who directed her to notify R1's family and call 911. R1 was prounounced dead upon emergency response personnel arrival at the scene.

An embalming report dated December 24, 2022, identified indents noted on R1's face and neck and identified the indents were from the bar of R1's bed.

R1's family provided photographs of R1's side rail, but observation and measurement of R1's side rail was not possible, due to R1's belongings having been packed and returned to family members. Photographs provided identified the use of a side rail not grab bar/bed cane as indicated on R1's assessment.

R2
R2 began receiving services June 12, 2015. R2's diagnoses included multiple sclerosis, seizure disorder, depression, and emphysema.

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R2's service plan dated October 1, 2022, indicated R2 received services including medication management, assistance with mobility, assistance with transfers, toileting, dressing, vital sign monitoring, and laundry.

On February 8, 2023, at 10:33 a.m., investigators entered R2's room and observed bilateral bed rails, described as Old Style #1 bed rails. Investigators observed facility staff complete side rail measurements in accordance with United Stated Food & Drug Administration (FDA) guidance. However, the facility lacked manufacturer information, and without that information, they were unable to assess and determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident.

R3
R3 began receiving services August 28, 2019. R3's diagnoses included hydrocephalus, dizziness, polyneuropathy, and glaucoma.

R3's service plan dated October 1, 2022, indicated R3 received services including medication management, vital signs, assistance with bathing, dressing, toileting, and grooming, laundry, and housekeeping.

On February 8, 2023, at 11:11 a.m., investigators entered R3's room and observed bilateral bed rails, described as Old Style #1 bed rails. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. However, the facility lacked manufacturer information, and without that information, they were unable to assess and

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determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident.

R4
R4 began receiving services October 12, 2019. R4's diagnoses included stroke, diabetes type II, convulsions, and encephalopathy.

R4's service plan dated October 1, 2022, indicated R4 received services including medication management, assistance with showering and dressing, laundry, and housekeeping.

On February 8, 2023, at 11:02 a.m., investigators entered R4's room and observed a side rail on the right side of the bed, described as the Safety Glo Rail. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. The facility possessed manufacturer information for the Safety Glo Rail and it was found that the manufacturer recommended the strapped webbing be run under the mattress and around the bed frame/base. However, R4's strapped webbing was found to be run around the mattress, rather than the bed frame, which could lead to instability of the rail and discomfort for the resident. The manufacturer also recommended bed rail placement be checked daily, which was not being completed by the licensee.

R5
R5 began receiving services on November 21, 2019. R5's diagnoses included lumbar compression fractures, degenerative arthritis, chronic obstructive pulmonary disease, and nocturia.

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R5's service plan dated November 21, 2022, indicated R5 received services including medication management, assistance with bathing, dressing, toileting, grooming, vital sign monitoring, and laundry.

On February 8, 2023, at 10:15 a.m., investigators entered R5's room and observed a bed rail on the left side of the bed, described as Old Style #1 bed rail. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. It was found that the mattress was easily pushed to the other side of the bed, leading to a large gap between the mattress and the rail. The facility also lacked manufacturer information, and without that information, they were unable to assess and determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident.

R6
R6 began receiving services on January 5, 2014. R6's diagnoses included congestive heart failure, osteoporosis, and high blood pressure.

R6's service plan dated October 1, 2022, indicated R6 received services including medication management, bathing, dressing, grooming, and laundry.

On February 8, 2023, at 10:43 a.m., investigators entered R6's room and observed a side rail on the right side of the bed, described as the Safety Glo Rail. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. However, it was found that the mattress was able to be pushed to the opposite side of the bed, creating a gap between

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LILYDALE SENIOR LIVING	949 SIBLEY MEMORIAL HIGHWAY LILYDALE, MN 55118

(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
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the right side of the mattress and the side rail. The manufacturer information recommended bed rail placement be checked daily, which was not being completed by the licensee. It was noted the mattress on R6's bed was easily moved from side to side in the bed frame, with the possibility of creating a gap between the bed rail and mattress.

R7
R7 began receiving services on November 3, 2017. R7's diagnoses included multiple sclerosis, fibromyalgia, and seizure disorder.

R7's service plan dated October 1, 2022, indicated R7 received assistance with medication management, repositioning, vital sign monitoring, activities of daily living, and laundry.

On February 8, 2023, at 10:06 a.m., investigators entered R7's room and observed bilateral bed rails, described as Hospital Style #1 bed rails. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. However, the facility lacked manufacturer information, and without that information, they were unable to assess and determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident.

R8
R8 began receiving services on November 23, 2021. R8's diagnoses included dementia, high blood pressure, and hypothyroidism.

R8's service plan dated October 1, 2022, indicated R8 received assistance with medication management, vital sign monitoring, activities of daily living, and housekeeping.

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On February 8, 2023, at 10:50 a.m., investigators entered R8's room and observed bilateral bed rails, described as Hospital Style #2 bed rails. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. However, the facility lacked manufacturer information, and without that information, they were unable to assess and determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident.

R9
R9 began receiving services May 16, 2022. R9's diagnoses included left femur fracture, multiple sclerosis, dementia, and diabetes type II.

R9's service plan dated October 1, 2022, indicated R9 received assistance with medication management, repositioning, activities of daily living, and laundry.

On February 8, 2023, at 10:21 a.m., investigators entered R9's room and observed bilateral bed rails, described as Hospital Style #1 bed rails. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. However, the facility lacked manufacturer information, and without that information, they were unable to assess and determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident.

R10
R10 began receiving services June 17, 2022. R10's diagnoses included bilateral forearm

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02310	Continued From page 12 fractures, heart failure, peripheral vascular disease, chronic kidney disease stage 4, and atrial fibrillation. R10's service plan dated October 1, 2022, indicated R10 received assistance with medication management, activities of daily living, vital sign monitoring, laundry, and housekeeping. On February 8, 2023, at 10:24 a.m., investigators entered R10's room and observed a bed rail on the left side of the bed, described as Old Style #2 bed rail. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. However, the facility lacked manufacturer information, and without that information, they were unable to assess and determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident. R11 R11 began receiving services on July 1, 2022. R11's diagnoses included Parkinson's disease, arthritis, and Lynch syndrome. R11's service plan dated October 1, 2022, indicated R11 received assistance with medication management, activities of daily living, vital signs, and laundry. On February 8, 2023, at 10:37 a.m., investigators entered R11's room and observed bilateral bed rails, described as Old Style #1 bed rails. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. However, the facility lacked manufacturer information, and without that information, they were unable to assess and	02310		

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determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident.

R12
R12 began receiving services on September 23, 2022. R12's diagnoses included history of falls, fracture of thoracic vertebrae, macular degeneration, osteoporosis, scoliosis, and transient ischemic attack.

R12's service plan dated November 8, 2022, indicated R12 received assistance with medication management, activities of daily living, meals, and vital sign monitoring.

On February 8, 2023, at 10:49 a.m., investigators entered R12's room and observed bilateral bed rails, described as Old Style #1 bed rails. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. However, the facility lacked manufacturer information, and without that information, they were unable to assess and determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident.

R13
R13 began receiving services on July 9, 2021. R13's diagnoses included left femur fracture, high blood pressure, heart disease, chronic obstructive pulmonary disorder, and glaucoma.

R13's service plan dated October 1, 2022, indicated R13 received assistance with medication management, vital sign monitoring, activities of daily living, ambulation, and laundry.

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On February 8, 2023, at 10:05 a.m., investigators entered R13's room and observed a side rail on the right side of the bed, described as the Safety Glo Rail. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. The facility possessed manufacturer instructions, however, the manufacturer recommended bed rail placement be checked daily, which was not being completed by the licensee.

R14
R14 began receiving services on April 28, 2021. R14's diagnoses included asthma, arthritis, neuropathy, fibromyalgia, right femur fracture, dementia, hearing loss, and osteoarthritis.

R14's service plan dated October 1, 2022 indicated R14 received assistance with medication management, activities of daily living, behavioral interventions, vital sign monitoring, and laundry.

On February 8, 2023, at 10:00 a.m., investigators entered R14's room and observed a side rail on the right side of the bed, described as the Safety Glo Rail. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. The facility possessed manufacturer instructions, however, the manufacturer recommended bed rail placement be checked daily, which was not being completed by the licensee.

R15
R15 began receiving services on December 7, 2022. R15's diagnoses included atrial fibrillation, cardiomyopathy, high blood pressure, and ovarian cancer.

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R15's service plan dated January 12, 2023, indicated R15 received assistance with medication management, activities of daily living, meals, and housekeeping.

On February 8, 2023, at 10:09 a.m., investigators entered R15's room and observed bilateral bed rails, described as Old Style #1 bed rails. Investigators observed facility staff complete side rail measurements in accordance with FDA guidance. However, the facility lacked manufacturer information, and without that information, they were unable to assess and determine if the bed rails were being used appropriately and installed properly, which resulted in an imminent safety risk for the resident.

All fifteen records reviewed (R1-R15) lacked assessment and documentation of the use of side rails including:
-Risk vs. benefits discussion individualized to each resident's risks;
-Documentation of installation, use, and maintenance according to manufacturer's guidelines;
-Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation;
-Documentation of any necessary information related to interventions to mitigate safety risks;
-Documentation of updated bed rail assessment at least every 90 days;
-Documentation that the bed rails were determined to not act as a restraint;
-Documentation that bed rails were installed and maintained according to the manufacturer's guidelines;
-Readily accessible manufacturer's bed rail

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02310	Continued From page 16 guidelines. The Food and Drug Administration (FDA), "Recommendations for Health Care Providers about Bed Rails," dated July 9, 2018, included the following information: -Follow the health care facility's procedures and/or manufacturer's recommendations/specifications for installing and maintaining bed rails for the particular bed frame and bedside rails used. -Inspect and regularly check the mattress and bedrails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and/or depth, the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. -Regularly assess that bed rails remain appropriately matched to the equipment and to the patient's needs, considering all relevant risk factors. -Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. -Re-assess the person's needs and re-evaluate the equipment if an episode of entrapment or near-entrapment occurs, with or without serious injury. This should be done immediately because fatal "repeat" events can occur within minutes of the first episode. -Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or water bed. -When in doubt, call the manufacturer of the rails for assistance.	02310		

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The Minnesota Department of Health's Assisted Living Resources & Frequently-asked Questions: Consumer Bed Rails, dated November 29, 2022, indicated documentation about a resident's bed rails includes, but is not limited to:
-Purpose and intention of the bed rail
-Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail
-The resident's bed rail use/need assessment
-Risk vs. benefits discussion (individualized to each resident's risks)
-The resident's preferences
-Installation and use according to manufacturer's guidelines
-Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation
-Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements

The Minnesota Department of Health's Assisted Living Resources & Frequently-asked Questions: Consumer Bed Rails, dated November 29, 2022 further included that if a facility is unable to locate manufacturer's guidelines, the facility is unable to assess and determine if the portable bed rail is being used appropriately and installed properly, resulting in an imminent safety risk for the resident.

During an interview on February 8, 2023, at 3:00 p.m., the registered nurse (RN)/Director of Nursing (RN-A) and licensed practical nurse (LPN)-B expressed lack of knowledge regarding the following requirements:
-Risk vs. benefits discussion to be individualized to each resident's risks;

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02310	Continued From page 18 -There should be documentation of installation, use, and maintenance according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation should be documented; -Necessary information related to interventions to mitigate safety risks should be documented; -Bed rail assessments should be completed at least every 90 days; -It should be documented that the bed rails were determined to not act as a restraint; -It should be documented that bed rails were installed and maintained according to the manufacturer's guidelines; -Manufacturer's bed rail guidelines should be readily accessible. A licensee policy titled Side Rails, dated August 1, 2021, stated the facility would assess the use, educate the resident/responsible person regarding the use of side rail(s), and verify the side rail(s) is/are of a safe design and utilized consistent with the manufacturer's directions. The policy would be followed regardless of who owned or supplied the side rail(s). No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 19 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03020 SS=J	626.557 Subd. 4 Reporting (a) Except as provided in paragraph (b), a mandated reporter shall immediately make an oral report to the common entry point. The common entry point may accept electronic reports submitted through a web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under	03020		

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03020	Continued From page 20 sections 144.291 to 144.298, to the extent necessary to comply with this subdivision. (b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.13. The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report sufficient data to the common entry point (CEP) regarding an incident which occurred involving one of one residents (R1) with records reviewed. Although the resident was found deceased and entrapped in a siderail, the facility did not report all of the details of the incident and reported the incident as "self neglect." This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only	03020		

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occasionally).

Findings include:

R1 began receiving services April 29, 2022. R1's diagnoses included Parkinson's disease, high blood pressure, restless leg syndrome, osteoarthritis, and closed fracture of the left humerus.

R1's service plan dated December 15, 2022, indicated R1 received services including medication management, vital signs, showering, laundry, and assistance with transfers.

An incident report dated December 24, 2022, at 6:18 a.m. indicated a staff member went in to R1's room for a scheduled visit and found R1 unresponsive, not breathing, and noted R1's right arm was holding the inside of the grab bar and R1's neck was resting on the grab bar with R1's body on the floor. The staff member immediately contacted the facility nurse, who directed her to notify R1's family and call 911. R1 was pronounced dead upon emergency response personnel arrival at the scene.

During interview on January 20, 2023, at approximately 1:00 p.m. registered nurse (RN)-A stated staff called her the morning of December 24, 2022, regarding R1 and she immediately came into the facility. RN-A stated when the funeral staff came to transport the resident to the funeral home, it took several staff to lift up the mattress to get the residents right arm out from between the mattress and the siderail. The nurse also stated the resident had an alarm clock cord wrapped around the grab bar about 2 or 3 times which had to be untwisted before they could lift up the mattress to get the resident out from between

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the mattress and the siderail.

During interview on January 20, 2023 at approximately 1:30 p.m. licensed practical nurse (LPN)-B stated the morning of R1's death staff called her and she immediately went to the facility. LPN-B stated the resident was on the floor not breathing, her right arm was inside of the siderail, the "left side of her neck was against the side rail," and the resident was "face down." The nurse stated the siderail was so tight to the mattress staff had to lift the mattress off the bed to get the resident out from between the siderail and the mattress.

An embalming report dated December 24, 2022, identified indents noted on R1's face and neck and identified the indents were from the bar of R1's bed.

The facility provided a report to the Minnesota Adult Abuse Reporting Center (MAARC) dated December 24, 2022. The MAARC report indicated self-neglect as the concern. The report indicated staff went to check on R1 and she "was found leaning on the floor" with R1's "left arm stuck in between the bedrail. [Resident] was deceased."
The MAARC report lacked description of the extent of R1's entanglement in the side rail and lacked to account for the possibility of facility neglect.

The facility's policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, dated August 1, 2021, indicated the facility developed individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information.

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03020	Continued From page 23 TIME PERIOD FOR CORRECTION: Two (2) days.	03020		