*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL307264344M
**Compliance #:** HL307267356C

**Date Concluded:** June 7, 2023

**Name, Address, and County of Licensee Investigated:**
Arlington Place
21 16th Avenue Southeast
St. Joseph, MN 56374
Stearns County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Carol Moroney RN, Special 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 a resident when the resident was found on the floor, on his knees in front of the bed with his head stuck between the bed rails and the mattress. The resident's face was purple in color.

**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 proper measurements and bed rail maintenance was provided for safe use resulting in the resident's head getting stuck between the bed rail and the mattress when he fell out of bed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice organization and law enforcement. The investigation included review of service plan, assessment, bed and bed rail

measurements, incident reports, hospice notes, resident notes and services provided documentation.

The Food and Drug Administration (FDA) guidelines for bed rails indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. When installing and using bedrails, select the appropriate bed rail, follow the health care provider's procedures, or manufacturer's recommendations, inspect, evaluate, and regularly check bed rails are appropriately matched to equipment and resident's needs. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by resident weight, movement, bed position, or by using a specialty mattress.  FDA bed rail zone measurement guidelines indicated zones 1 through 4 have a common risk for entrapment and required specific measurement range.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, and urinary incontinence. The resident's service plan included assistance with repositioning in bed, transferring, bathroom usage, bathing, and activities of daily living. The resident had a history of falls and fell four times in the five months prior to the incident.

The resident's registered nurse (RN) assessment indicated the resident was at risk for falls. Interventions included a call pendant for the call system worn around his neck. The resident was assessed as able to appropriately use this to call for assistance as needed. The resident needed two people to transfer and was unable to walk. The assessment indicated the use of the bed rail was for turning and repositioning.

The resident's bed rail assessment indicated the facility measured bed rail did not meet the FDA requirements, except for zone 1. Zones 2 through Zone 4 were documented as "N/A" (not applicable) although FDA requires measurements for safety size. Zone 5 was not applicable due to the use of split side rails. Zone 6 measurements were three inches between the end of the rail and side edge of the headboard or footboard (did not specify which area was measured). Zone 7 included measurements were four inches between the head or footboard and the mattress.

The facility incident report indicated the resident was found on the floor, on his knees, facing the bed with his head caught in between the bed rail and the mattress. The resident's head and face were purple. Progress notes indicated the resident was not responsive aside from a few mumbles. Staff were able to remove the resident's head from the entrapment, but it was a tight squeeze. Upon release, staff were unable to lift the resident and law enforcement responded to assist the resident back into bed. When the RN became aware of the incident, unlicensed personnel were instructed to remove the bed rail the same day.

Investigative interviews with the ULP staff who worked the day of the incident stated the resident was found about an hour after they were in the room to give medications. The resident

was on his knees on the floor, facing the bed with his head caught between the bed rail and the mattress. The resident was mumbling but not yelling. The resident's head and face were purplish in color. The ULP staff on night shift also stated the hospice nurse requested to have the bed rail to be removed. The ULP said he was not trained how to remove the rail but was able to figure it out. In addition, the resident had two safety checks. The staff reported there was no training provided to them about bedrail spacing requirements and expectations. The facility staff also reported the facility had no process to report a loose bedrail or know who to contact.

During an interview, nurse 1 stated the resident had a steady decline [in health] after the incident.

During onsite observations with the licensed assisted living director (LALD) of two current residents (the vulnerable adult had since died at the time of the investigation) with bed rails, it was found the bed rails were loose. The residents' bed rail assessments were missing measurements for zones 2 and 4. Maintenance was notified to tighten the bed rails.

During an interview, maintenance personnel stated he had no training on bed rails and the risks involved in using them. The maintenance personnel stated there were no preventative maintenance completed on bed rails or the rail gaps. He stated he tightened the bed rails if someone requested for it to be done. The maintenance personnel stated he received a request approximately twice during his employment.

During an interview, nurse 2 stated bed rail measurements are completed at the time of the assessments. Nurse 2 completed the initial measurements and risk benefit agreement. Nurse 2 confirmed the staff had not received education on bed rails prior to the incident but the staff will receive training on bed rails.

During an interview, the LALD stated at the time of the incident, the staff were supposed to let the RN know if the rails were loose but there was no training or documentation. The LALD stated the facility has now put into place the expectations for the staff to check the residents' bed rails and document their findings every shift. The LALD stated she would find training on bed rail safety and will ensure the staff have viewed it.

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, the resident is deceased.

**Family/Responsible Party interviewed**: Yes.

**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:**
The facility has educated all the staff on bed rails and reassessed all the beds with attached rails.

**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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4890 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Stearns County Attorney
St Joseph’s City Attorney
St Joseph’s Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL307264344M/#HL307267356C<br><br>On March 23, 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 20 residents receiving services under the provider's Assisted Living Facility license.<br><br>The following correction order is issued for #HL307267356C/#HL307264344M, tag identification 2310 and 2360. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 02310 SS=I | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 1<br>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 standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, observation, and record review, the licensee failed to measure all bed rail zones to determine if the siderails met the Federal Drug Administration (FDA) safety requirements for three of three residents (R1, R2, R3) with bedrails. R1 became entrapped in the bed rail when he fell out of bed and his face had become purple in color.<br><br>This practice resulted in a level three violation (a violation that harmed a resident'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 residents).<br><br>The findings include:<br><br>The FDA guidelines titled Recommendations for Health Care Providers about Bed Rails, dated July 9, 2018, indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bed rails, mattresses, and bed frames are | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 2<br><br>interchangeable; check the manufacturer's instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails, select the appropriate bed rail, follow the health care provider's procedures, or manufacturer's recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress.<br><br>The FDA identifies vulnerable patients as those "who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance." These patients most often have been frail, elderly, or confused. FDA guidelines titled Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 2006, identified key body parts at risk for life-threatening entrapment of the head, neck, and chest in the seven zones of a hospital bed system, focusing on the most common zones for risk of entrapment - zones 1-4.<br>Zone 1 - within the rail is any open space with the perimeter of the rail. Recommended space be less than 4 ¾ inches representing head breadth.<br>Zone 2 - under the rail, between the rail supports or next to a single rail support. This space is the gap under the rail between a mattress compressed by the weight of a patient's head and | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 3<br><br>the bottom edge of the rail at the location between the rail supports or next to a single rail support. Recommended space limit for entrapment in this space is less than 4 ¾ inches. Zone 3 - between the rail and the mattress. The space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment. Recommended space between the area between the inside surface of the rail and compressed mattress should be of less than 4 ¾ inches. Zone 4 - under the rail at the ends of the rail. This space poses a risk for entrapment of a patient's neck. In this space, a gap forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. Recommended dimension for this zone measure both less than 60 mm in size and greater than 60 degrees in angle. Zone 5, 6, and 7 are identified as potential for entrapment with the least reporting. Zone 5 is the area between the split of bedrails, zone 6 is the between the end of rail and the side edge of the head or footboard, and zone 7 is between the head or footboard at the end of the mattress.<br><br>R1<br>R1's diagnoses included, dementia, hypertension, and urinary incontinence. R1's service plan dated June 13, 2022, indicated R1 required assistance with ambulation, bathing, behavior management dressing, escort, exercises, grooming and medication management.<br><br>R1's most recent assessment dated November 20, 2022, indicated R1 required total assistance with bathing, dressing, and undressing and grooming. R1 required full assistance to sit up in bed, to be turned and repositioned. R1 required | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 4<br><br>two people to transfer. R1 required assistance with medication administration. R1's had a hospital bed with unilateral half side rails on the top of the bed to assist R1 with transfers and bed mobility.<br><br>R1's bed rail assessment dated November 30, 2022, indicated the facility measured bed rail did not meet the FDA requirements, except for zone 1. Zones 2 through Zone 4 were documented as "N/A" (not applicable) although FDA requires measurements. Zone 5 was not applicable due to the use of split side rails. Zone 6 measurements were three inches between the end of the rail and side edge of the headboard or footboard (did not specify which area was measured). Zone 7 included measurements were four inches between the head or footboard and the mattress.<br><br>R1's progress note dated December 28, 2022, at 10:55 a.m., indicated unlicensed personnel (ULP)-F's walked into R1's room and found R1 had fallen on the floor, kneeling on the floor with his head stuck between his bed rail and mattress. Staff were able to release his head from the position it was in but were not able to lift him off the floor. The police came and assisted him back into bed. Vitals were not taken due to the situation. R1 was not responsive aside from a few mumbles after his fall.<br><br>R1's progress note dated December 28, 2022, at 8:52 p.m., written by licensed practical nurse (LPN)-C, indicated staff reported an unwitnessed fall. Staff entered R1's room to find R1 on his knees facing next to the bed. R1's head was stuck between the bed rail and the mattress. LPN-C wrote staff reported R1's face was purple in color while between the bed rail and the mattress. The staff were able to dislodge R1's | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 5<br><br>head. R1 was agitated. The staff were able to assist R1 back to bed with assist of the police.<br><br>R1's progress note dated December 28, 2022, at 11:46 p.m., written by registered nurse (RN)- I's indicated ULP-F stated staff were able to assist his head out of the bed rail, but it was a very tight squeeze. RN-I requested the bed rails be removed by staff.<br><br>R1's incident report dated December 28,2022, at 6:00 p.m., indicated R1 was found on his knees with his head lodged between the bed rail and the mattress. R1's head and face looked a little purple. Following the event, R1's neck hurt to be moved and R1 had a scrape on his left arm and right hip/thigh. 911 was called so the staff could get assistance moving R1 to his bed.<br><br>During an interview on March 22, 2023, at 11:30 a.m., RN-B stated the bed rails were secured to the hospital bed. He received a text message from LPN-C notifying of the event and RN-B stated he thinks the staff found R1 on his knees facing the bed with his head caught within the rails.<br><br>On March 27, 2023, at 1:30 p.m., RN-I stated R1 was minimally alert and confused when she arrived. RN-I did not assess the rail but requested the night ULP to remove the bed rails. RN-I stated R1 was on a steady decline after the event.<br><br>R2<br>R2 diagnoses included depression, liver failure with encephalopathy, acute kidney failure and hypotension. R2's service plan dated April 19, 2023, indicated R2 required assistance with | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 6<br><br>showering, exercises, housekeeping, and medication administration.<br><br>R2's most recent assessment dated February 1, 2023, indicated R2 required some assistance with bathing, dressing, anti-embolism stocking on and off (to increase blood flow in the legs). R2 had a bed rail for assistance with positioning.<br><br>R2's bed rail assessment dated February 1, 2023, indicated bed rail measurements did not meet the FDA requirements, except Zone 1 and Zone 3. Zone 2 and 4 did not include required measurements. Zone 5 was not applicable due to the use of split side rails. Zone 6 measurements were 4.5 inches between the end of the rail and side edge of the headboard or footboard (did not specify which area was measured). Zone 7 included measurements were 4.5 inches between the head or footboard and the mattress.<br><br>R3<br>R3's diagnoses included depression, and seizure disorder. R3's service plan dated February 10, 2023, indicated R3 received assistance with bathing, assistance device for bed repositioning, and medication administration.<br><br>R3's most recent assessment dated February 10, 2023, indicated R3 required some assistance with bathing. R3 was independent with dressing, grooming, transfer and ambulation. R3 had a bed rail for assistance with positioning.<br><br>R3's bed rail assessment dated February 10, 2023, indicated bed rail measurements did not meet the FDA requirements, except Zone 1 and Zone 3. Zone 2 and 4 did not include required measurements. Zone 5 was not applicable due to | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 7<br><br>the use of split side rails. Zone 6 measurements were one inches between the end of the rail and side edge of the headboard or footboard (did not specify which Zone 7 included measurements were two inches between the head or footboard and the mattress.<br><br>During an interview and observation of R2 and R3's bed and bed rails on March 22, 2023, at 10:45 a.m., with licensed assisted living director (LALD)-A, LALD-A confirmed the rails on R2 and R3's bed were extremely loose and said the bed rail will be removed today. No measurements were taken.<br><br>During an interview on March 30, 2023, at 1:45 p.m., maintenance personnel (MP)-J, stated he had no training on bed rails and the risks involved in using them. MP-J stated there are no preventative maintenance completed on bed rails or the rail gaps. MP-J stated he only tightened the bed rails if someone requested for it to be done. MP-J stated he received a request approximately twice during his employment.<br><br>During an interview on April 19, 2023, at 1:40 p.m., LPN-C stated it is not her responsibility to do anything with the bed rails. LPN-C stated she does not measure them, the RN does. LPN-C stated the staff do not report bed rail concerns to her.<br><br>During an interview on April 19, 2023, at 1:50 p.m., RN-B stated he does the measurement at the time of the assessments. RN-B completed the initial measurements and risk benefit agreement. RN-B expects the staff to check the rails to check tightness and notify him if there was a problem. RN-B confirmed the staff had not received education on bed rails prior to the event | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 8<br><br>but the staff will receive training currently on bed rails.<br><br>During an interview on April 20, 2023, at 7:55 a.m., LALD-A stated at the time of the event, the staff were supposed to let RN-B know if the rails were loose but there was no training or documentation that the staff were trained or assigned to complete this task. LALD-A stated the facility has now put into place the expectations for the staff to check the residents' bedrails and document their findings every shift. LALD-A stated she would find training on bed rail safety and will ensure the staff have viewed it this week.<br><br>The licensee's Side Rails policy revised August 1, 2021, noted when site is aware a home care resident is utilizing side rails (a medical device) on a bed, site will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The side rails must be installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75"<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30726 | A. BUILDING: _____ B. WING _____ | C 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON PLACE | 21 16TH AVENUE SE SAINT JOSEPH, MN 56374 |

| (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 |
|---|---|---|---|---|
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>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. | |