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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL387442922M
**Compliance #:** HL387444857C

**Date Concluded:** May 15, 2023

**Name, Address, and County of Licensee Investigated:**

Suite Living Senior Care
938 South Robert Street
West St. Paul, MN 55118
Dakota County

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

**Evaluator's Name:** Peggy Boeck, RN
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.

**Initial Investigation Allegation(s):**
The facility neglected a resident when they failed to reassess a bedrail consistent with the manufacturer's recommendations for monitoring and the resident became trapped 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 have a system in place that included ensuring bedrails were securely attached with spaces small enough between the mattress and bedrails to prevent entrapment. The facility failed to follow the recommended guidelines for measuring zones (open space) of potential areas for entrapment and failed to monitor the bedrails for increased space in the zones, due to use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the medical examiner's office, law enforcement, and family. The investigation included review of U.S. Department of Health

and Human Services Food and Drug Administration Center for Devices and Radiological Health Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment (FDA guidelines), medical records, incident reports, law enforcement records, policies, and procedures related to assessments, changes in resident condition, emergency preparedness, abuse prevention, service plans, risk agreements, side rails, staffing, and maltreatment of vulnerable adults.

The investigator did not observe or measure the bed of the resident who died, as the bed had been removed the day after the incident. The investigator observed and video recorded the stability/movement of bedrails of the six residents who utilized bedrails at the facility at the time of the investigation. Five of the six residents' bedrails were unstable/loose, moving several inches away from the mattress, which created spaces large enough for a residents' head to become entrapped between the mattress and bedrail.

The resident lived in an assisted living unit. The resident's diagnoses included chronic obstructive pulmonary disease (COPD) and obesity. The resident's assessment indicated the resident required continuous oxygen and transfer assistance of two staff with a sit to stand mechanical lift due to an inability to walk. The resident's service plan indicated the resident received services that included assistance with dressing, toileting, medication administration, and mobility.  The resident's bedrail assessment indicated staff provided the resident with toileting assistance and frequent monitoring at night,  The assessment did not define the frequency.

The resident's bedrail risk agreement indicated the facility planned to assess the resident's bedrails for safety and measure for appropriate spacing (including the space between the mattress and the bedrail) every three months or as needed.

Progress notes in the resident's medical record indicated one morning staff found the resident in her room with her head/neck trapped between the mattress and bedrail with her knees/feet on the floor. The report indicated several staff removed the resident and placed her on the floor, where they determined she was not breathing. A staff called the on-call nurse (an administrative nurse) and 911. The progress note indicated the resident had a do not resuscitate order (DNR), so staff did not start cardiopulmonary resuscitation (CPR) but remained with the resident until the police and medical examiner arrived.

During an interview, the administrative nurse stated she received a call about the incident and directed staff to call 911. The administrative nurse stated the facility investigation of the incident included interviews with night staff, who stated they last checked on the resident two hours prior to the discovery of the entrapment. The administrative nurse stated a nurse completed a bedrail assessment and measured the spaces according to the FDA guidelines the day the medical supply company attached the bedrails to the resident's bed, one week prior to the incident. The administrative nurse stated they received no manufacturer guidelines for the bedrails.

During an interview, a nurse stated she measured the resident's bedrails including the space between the mattress and bedrail a week before the incident. The nurse stated she had no training on the recommended process for ensuring the spaces met the FDA guidelines. The nurse stated she had read the FDA guidelines "a while ago" and the facility process was to reassess and re-measure the bedrails every 90 days. The nurse stated she relied on staff to notify nursing if the bedrails were "too loose". The nurse defined too loose as "if I can move it several inches".

During investigative interviews, multiple staff members stated they did not monitor the bedrail attachment, stability, or the spaces between the mattress and bedrails.

During interviews, family members stated they believed the facility would check on the resident hourly and expressed concerns about staffing on the night shift as they had difficulty reaching staff by phone at night. The family members stated the resident became increasingly confused over the course of the week she was at the facility and nights were particularly difficult.

The resident's cause of death was positional asphyxia, due to her head being wedged between the bedrail and mattress.

In conclusion neglect is 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 nurse inspected and tightened all current bedrails.

The facility reached out to the medical supply company for manufacturer's guidelines for the beds and bedrails. They updated the bedrail assessment, provided nurses and unlicensed staff with bedrail training, including new weekly inspection/assessment of bedrails.

**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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
West St. Paul City Attorney
West St. Paul Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38744 | A. BUILDING: _____ B. WING _____ | C 05/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SUITE LIVING SENIOR CARE OF WEST ST PAU | 938 SOUTH ROBERT STREET WEST SAINT PAUL, 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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| 0 000 | Initial Comments<br><br>******ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, 144G.08 to 144G.95, this correction order is 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>******Revised******<br><br>#HL387442922M/#HL387444857C<br><br>On May 3-9, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order issued. At the time of the complaint investigation, there were 20 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following immediate correction order is issued for #HL387442922M/#HL387444857C, tag identification 2310.<br><br>On May 9, 2023, the immediacy of the correction order tag 2310 has been removed however, non-compliance remains at a scope and severity of L. | 0 000 | The Minnesota Department of Health documents the State 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction.<br><br>Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations.<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. | |

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| 0 000 | Continued From page 1<br>Correction orders with a time period to correct that are not immediate may be issued at a later date during the investigation. | 0 000 | THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3. | |
| 02310 SS=L | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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 standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for six of six residents (R1, R2, R3, R4, R5, and R7)) who utilized bedrails. Harm occurred when R1's neck became entrapped between her mattress and bed rail, and R1 died.<br><br>This resulted in an immediate correction order on May 3, 2023.<br><br>The immediacy is removed as confirmed by the surveyor's on-site observations on May 9, 2023, and review by the rapid response supervisor on May 9, 2023, however, noncompliance remains at a scope and severity of L.<br><br>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 | 02310 | | |

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| 02310 | Continued From page 2<br>systemic failure that has affected or has potential to affect a large portion or all the residents).<br><br>Findings include:<br><br>During observations of resident rooms who utilized bedrails on May 3, 2023, from 9:21 a.m. through 10:14 a.m. the investigator observed and took video of the following:<br><br>R1's bed was not in the facility at the time of the investigation. A photo of R1's bed taken by the medical examiner showed the bed had half rails at the head of the bed on both sides, and at the time of the photo, the lower half of the bed (the foot end) was elevated.<br><br>R2's bed had half rails on both sides at the head of the bed. The rails were loosely attached, moved from side to side (away from and towards the mattress) and back and forth (parallel to the mattress) which increased by several inches the gap in zone 3 (identified by the U.S. Department of Health and Human Services Food and Drug Administration as the space between the bedrail and mattress).<br><br>R3's bed had half rails on the right facing side at the head of the bed. The rail on the right facing side was loosely attached, moved from side to side and back and forth, which increased the gap in zone 3 by several inches.<br><br>R4's bed had half rails on both sides at the head of the bed. The rail on the left facing side of the bed was loosely attached, moved from side to side and back and forth, which increased the gap to zone 3 by several inches.<br><br>R5's bed had half rails on both sides at the head | 02310 | | |

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| 02310 | Continued From page 3<br><br>of the bed. The rail on the left facing side of the bed was loosely attached, moved from side to side and back and forth, which increased the gap in zone 3 by several inches.<br><br>R7's bed had one half rail on the left facing side at the head of the bed. The rail on the left facing side of the bed was loosely attached, moved from side to side and back and forth, which increased the gap in zone 3 by several inches. The other half rail was on the floor, unattached, on the right facing side of the bed.<br><br>R1<br><br>R1 admitted to the facility on August 18, 2022, due to diagnoses that included chronic obstructive pulmonary disease (COPD), hypertension, obesity, and chronic kidney disease.<br><br>R1's Assessment for Client Vulnerability, Safety, and Risk to Others document dated August 18, 2022, indicated R1 was non-ambulatory, required a sit to stand mechanical lift with assistance of two staff for transfers, and had limited range of motion in her arms.<br><br>R1's Service Plan dated August 18, 2022, indicated R1 required "regular or frequent" assistance to/from the bathroom, had no memory loss, was oriented, able to recall, and retain information. The service plan did not define the frequency of assistance provided.<br><br>R1's Bed Rail Assessment document dated August 18, 2022, indicated with a "no" check that R1 did not display poor bed mobility of difficulty moving to a sitting position on the side of the bed. The assessment indicated the following | 02310 | | |

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| 02310 | Continued From page 4<br><br>interventions checked: provide restorative care to enhance abilities to safely stand and walk, "provide frequent staff monitoring" at night, and visual and verbal reminders to use the call bell. The assessment indicated "Suite Living does not recommend the use of side rails due to potential for injuries due to entrapment". The assessment did not define the frequency of monitoring.<br><br>R1's progress note dated August 26, 2022, at 10:19 a.m., indicated a staff (not identified) notified registered nurse (RN)-B the staff found R1 with her head and neck stuck between the mattress and the bedrail, R1 was not breathing, and appeared deceased.<br><br>During an interview on May 3, 2023, at 12:56 p.m. unlicensed personnel (ULP)-A stated on the day of the incident ULP-A worked the morning shift and found it unusual to not hear R1 pressing her call light to get up, as was her normal routine at that time of day. ULP-A stated she went into R1's room and saw R1's head/neck stuck in between the mattress and the bedrail with R1's legs on the floor. ULP-A stated R1 always seemed panicky when she was in her bed at night. ULP-A stated she did not recall ever seeing R1 use the bedrails to move in bed, and stated, "we helped her do everything".<br><br>During an interview on May 3, 2023, at 1:29 p.m. RN-B stated staff called to inform her R1 passed away from being stuck between the mattress and bedrail. RN-B viewed a photo (taken by the medical examiner) and verified R1's foot of the bed was elevated. RN-B stated she was unaware of R1 having any difficulty on the night shift. RN-B stated the facility added the statement "Suite Living does not recommend the use of side rails due to potential for injuries due to entrapment," | 02310 | | |

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| 02310 | Continued From page 5<br><br>on the licensee's bed rail assessment form when they were directed by the health department. RN-B stated the nurse who assessed R1 for bedrails would have R1 demonstrate her ability to use them appropriately.<br><br>During an interview on May 3, 2022, ULP-C stated R1 was confused, a fall risk, and did not appear to understand how to use her call light button.<br><br>During an interview on May 4, 2023, at 7:48 a.m. ULP-D stated R1 was restless and anxious on the night shift. ULP-D stated the staff wondered if R1 should be in the memory care unit. ULP-D stated staff had no responsibility with monitoring bedrails.<br><br>R2<br>R2 admitted to the facility on September 1, 2022, due to diagnoses that included a stroke with weakness/paralysis on her left side.<br><br>R2's Service Plan dated September 1, 2022, indicated R2 was non-ambulatory. The service plan had no information of services related to bedrails.<br><br>R2's Care Plan (a summary of services required used by unlicensed personnel) dated November 8, 2022, indicated R2 had half rails on her bed for mobility, and positioned herself in bed.<br><br>R2's Individual Abuse Prevention Plan (IAPP) dated November 8, 2022, indicated R2 had bedrails for bed mobility, and staff intervention was to "report concerns" with bedrails to nurse promptly.<br><br>R2's Bed Rail Assessment dated February 23, | 02310 | | |

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| 02310 | Continued From page 6<br><br>2023, indicated R2 attempted unsafe self transfers, staff were to provide "frequent monitoring at night" (frequency undefined) The assessment indicated "Suite Living does not recommend the use of side rails due to potential for injuries due to entrapment".<br><br>R3<br>R3 admitted to the facility on November 15, 202, due to diagnoses that included COPD, obesity, and muscle weakness.<br><br>R3's Care Plan (a summary of services required used by unlicensed personnel) dated November 11, 2022, indicated R3 had half bedrails for mobility and positioned herself in bed.<br><br>R3's Service Plan dated November 15, 2022, indicated R3 had a bedrail for mobility and instructed staff to complete "safety checks" of the bedrails "every shift".<br><br>R3's Bed Rail Assessment dated February 16, 2023, indicated R3 had a history of falls, had difficulty with balance, and attempted unsafe self-transfers. The assessment indicated staff interventions included "frequent staff monitoring at night" (frequency undefined). The assessment indicated "Suite Living does not recommend the use of side rails due to potential for injuries due to entrapment".<br><br>R4<br>R4 admitted to the facility on February 7, 2023, due to diagnoses that included cancer of breast/bone/lung/lymph nodes, anxiety disorder, obstructive sleep apnea, and obesity.<br><br>R4's Care Plan dated February 7, 2023, indicated | 02310 | | |

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| 02310 | Continued From page 7<br><br>R4 had half bedrails for mobility and positioned herself in bed.<br><br>R4's Service Plan dated February 7, 2023, indicated R4 had a bedrail for mobility and instructed staff to complete "safety checks" of the bedrails "every shift" and "report concerns to nurse".<br><br>R4's Bed Rail Assessment dated February 21, 2023, indicated R4 displayed poor bed mobility, difficulty with balance, and did not "express a desire to have" bedrails. The assessment indicated staff interventions of providing assisted toileting at night and reminders to use the call bell. The assessment indicated "Suite Living does not recommend the use of side rails due to potential for injuries due to entrapment".<br><br>R5<br>R5 admitted to the facility on March 14, 2023, due to diagnoses that included paraplegia.<br><br>R5's Care Plan dated March 14, 2023, contained no documentation of bedrails<br>.<br>R5's Service Plan dated March 14, 2023, contained no documentation of bedrails<br><br>R5's Bed Rail assessment dated March 29, 2023, indicated R5 had a history of falls, displayed poor bed mobility, and poor balance. The assessment indicated staff interventions to include lowering R5's bed to the floor, referral to Occupational therapy/Physical therapy, "frequent staff monitoring at night" (frequency undefined), assisted toileting at night, and reminders to use the call bell. The assessment indicated "Suite Living does not recommend the use of side rails due to potential for injuries due to entrapment". | 02310 | | |

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| 02310 | Continued From page 8<br><br>R7<br>R7 admitted to the facility July 8, 2022, due to diagnoses that included stroke with weakness/paralysis on left side and epilepsy.<br><br>R7's Care Plan dated July 8, 2022, contained no documentation of bedrails.<br><br>R7's Service Plan dated July 8, 2022, contained no documentation of bedrails.<br><br>R7's Bed Rail assessment dated March 29, 2023, indicated R7 was non-ambulatory, had altered safety awareness, and a history of falls. The assessment indicated staff interventions to include "frequent staff monitoring at night" (frequency undefined) and assisted toileting at night, and reminders to use the call bell. The assessment indicated "Suite Living does not recommend the use of side rails due to potential for injuries due to entrapment".<br><br>During an interview on May 3, 2023, at 12:56 p.m. unlicensed personnel (ULP)-A stated the staff did no safety checks with the bedrails and did not know who did.<br><br>During an interview on May 3, 2023, at 1:29 p.m. RN-B stated the bedrails were placed by a home medical supply company, who did not provide manufacturers guidelines to indicate maintenance requirements. RN-B stated the nurse assessed the resident for appropriateness of bedrails, ensured the bedrails were "tight" after installation, and would check the "tightness" of the bedrails every three months. RN-B stated staff "knew" to tell the nurse if they noticed something was wrong with the bedrails, but they received no training. RN-B stated the facility used the Food and Drug | 02310 | | |

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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 |
|---|---|---|---|---|
| 02310 | Continued From page 9<br><br>Administration (FDA) guidance for bedrails, but did not provide formal training for maintenance, unlicensed personnel, or nurses.<br><br>During interview on May 4, 2023, at 7:48 a.m. ULP-D stated the unlicensed staff did nothing with the resident bedrails.<br><br>The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br><br>The licensee's policy for bedrails dated July 20, 2021, indicated "Suite Living will assess the use, educate the resident about the risk and benefits of side rails, and verify the side rail is of a safe design and utilized consistent with manufacturer's direction".<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 02310 | | |
| 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. | 02360 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38744 | A. BUILDING: _____ B. WING _____ | C 05/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 02360 | Continued From page 10<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident(s) 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 is required for this tag. | |