STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0700 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to assess 1 of 1 residents (R1) for entrapment risk when a new air mattress was placed on the bed with siderails, this created an immediate jeopardy situation for R1 when R1 became entrapped between the mattress and siderail and died . The immediate jeopardy began on [DATE], when staff set up a new air mattress on R1's bed, and failed to assess for risk of entrapment and whether R1 was safe to use the new air mattress in conjunction with the bed rails. R1 died the morning of [DATE], when her neck became entrapped between the mattress and the side rail. The immediate jeopardy was identified on [DATE]. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 10:58 a.m. on [DATE]. The immediate jeopardy was removed and the deficient practice corrected on [DATE], prior to the start of the survey due to immediate actions taken by the facility, and was therefore Past Noncompliance. Findings include: The Guidance for Industry and FDA (Federal Drug Administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment Risk 2006, indicated bed systems should be reassessed when accessories such as mattresses are replaced. A neck may become trapped in a space of less than 2 ,[DATE] inches, or a head in less than 4 ,[DATE] inches. Zone 3 is described as the space between the rail and the mattress. The space between the rail and the mattress should be less than 4 ,[DATE] inches taking into account mattress compressibility, any lateral shift of the mattress or rail and degree of play from loosened rails. Powered air mattress replacements and similar pressure reduction products that have therapeutic benefits such as reducing pressure on skin are easily compressed by the weight of a patient and may pose additional risk of entrapment when used with conventional hospital bed systems. Vulnerable patients to becoming entrapped include those who are frail, elderly or confused. The User-Service Manual Joerns Assist Device and Side Rails Vari-Care Models, included, Warning: Risk of Serious Injury or Death .Vari-Care assist devices or side rails should not be used if ANY openings within the bed system allow a resident to get his/her head or neck lodged within these openings. Failure to do so could result in serious injury or death. When assessing the risk for entrapment, you need to consider your bed, mattress, head/foot panels, assist devices and other accessories, as a system. It is also extremely important to review the resident's physical and mental condition and initiate an appropriate individual care plan to address entrapment risk. R1's quarterly Minimum Data Set ((MDS) dated [DATE], included severe cognitive impairment with [DIAGNOSES REDACTED]. R1 required extensive assistance of 2 staff for all activities of daily living (ADL's) and did not have a life expectancy of less than 6 months. R1's progress note dated [DATE], 7:20 a.m. included, Around 3:00 a.m. writer was called to R1's room (R1's room number) in Gilber House. Writer observed elder's legs on the floor and the head between rail and mattress, left hand on the floor. 911 and Ramsey County Medical Examiner called. Family notified by DON (director of nursing). Medical Examiner talked to POA (power of attorney) and got consent to remove the body. Medical Examiner interviewed staff and the body was removed from the Facility about 0500 (5:00 a.m.). R1's incident report dated [DATE], included, At approximately 3:00 a.m. resident was found by the nursing assistant during rounds to be unresponsive. Facility administration, the medical examiner and police were notified. Resident's neck was found to be compressed against the bed rail. Resident's body was taken to the medical examiner's office for autopsy. The investigative report dated [DATE], included, A new bed rail assessment prior to the placement of a new air mattress on the resident bed frame was not completed. R1's Minnesota Documentation of Death report included date of death as [DATE], with immediate cause of death, asphyxia and, neck compression. The manner of death was an accident, head/neck was caught between mattress and bed rail. R1's most recent siderail assessment was dated [DATE], and included, R1 was nonambulatory, had an alteration in safety awareness due to cognitive impairment, and had a history of [REDACTED]. The assessment indicated, Side Rail serves as enabler to promote independence, and to use, bilateral, uses siderails for side to side repositioning. The space for medical indication for use was only indicated N/A. All side rail assessments for R1 were reviewed. The assessments were dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. None of R1's siderail assessments included, any alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate, or informed consent from R1 or R1's representative. None of these assessments assessed R1 for entrapment risk or indicated how those risks would be mitigated. R1's care plan revised [DATE], included, under activities of daily living section, a need for assistance for all ADL's and included, Side rails: half rails up for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. R1's care plan identified a high risk for falls and directed staff, Resident will have hourly checks during NOC (night) (when anxiety seems to elevated (sik)) to ensure safety. The resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night, ,[DATE] side rails as ordered, handrails on walls, personal items within reach). R1's care plan included R1 was at risk for pressure ulcer development, but did not direct staff to utilize a low air loss or alternating pressure mattress on bed. Even though R1's care plan included,observe for injury or entrapment related to side rail use, the care plan failed to direct staff on how to mitigate these risks or if the benefit of the rails outweighed the entrapment risk. R1's Nurse Practitioner (NP) progress note dated [DATE], included a recent cognitive and physical decline. R1's progress notes dated [DATE], described how R1 tested positive for COVID-19, and was transferred to a different unit for care. R1's progress note dated [DATE], described a small open area found on the right ankle. Progress notes on [DATE], noted R1 had recovered and was able to move back to R1's normal room. When interviewed on [DATE], at 11:05 a.m. the administrator stated R1 developed a skin issue while sick with COVID-19. After recovering from COVID-19, R1 transferred back to her regular room. On [DATE], R1 was given an alternating pressure air mattress (mattress that provides pressure redistribution by filling and un-filling air cells within the mattress so that the contact points with the body are reduced) to help with the pressure ulcer. When interviewed on [DATE], at 1:58 p.m. registered nurse (RN)-A stated side rail assessments were supposed to be completed quarterly, and confirmed that the most recent side rail assessment completed for R1 was in February 2020. No side rail assessment had been completed after replacing the regular mattress with the alternating pressure air mattress. Nursing is responsible for assessing the resident, the need for the siderail, the benefits and the risks and developing an individualized care plan. The facility policy for side rails dated [DATE], included, Half-side rails will be used only after an assessment has been made indicating a benefit to the resident's functional status. Continued use of the half-side rail will be reassessed periodically to determine if the side rail enhance the resident's mobility while in bed or

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

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F 0700 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) restricts the residents freedom of movement. The policy also included that maintenance monitors all side rails for gaps between the mattress and side rail, checks the mechanics of each side rail. The policy failed to include the need to perform a resident assessment for risk of entrapment, discussing the risks and benefits with the resident or their representative and obtaining informed consent, attempting alternatives prior to installing side rails, or a re-assessment if new devices/mattress is placed. When interviewed on [DATE], at 2:14 p.m. nursing assistant (NA)-C stated they had worked the afternoon shift before R1 became entrapped between the bed rail and mattress, R1 had declined some lately and required full staff assistance to move in bed and had not been using the siderails to assist with turning side to side lately. When interviewed on [DATE], at 2:35 p.m. the director of rehab stated R1 had a functional decline recently. Therapy would review siderails and inform nursing if something appeared unsafe, however, the director of rehab had not worked with R1 after receiving the new air mattress. When interviewed on [DATE], at 4:09 p.m. the administrator stated the air mattress was ordered and delivered on [DATE]. The administrator explained normally the facility's air mattress vendor would deliver and install the air mattress, but because of the COVID-19 pandemic, the vendor was not deemed essential to enter the building. Instead, a nursing assistant installed R1's air mattress on [DATE]. The administrator stated one issue the facility found during their investigation, was that the mattress was placed on [DATE], and had not been inspected by maintenance before R1 slept in the bed that night. Maintenance typically looked at the bed with the mattress, and side rails, to ensure safety, but had not checked the bed with the new mattress. Review of the work history report from the maintenance computer system showed a bed and mattress check for R1's unit on [DATE]. The Logbook Documentation showed the following steps for the bed and mattress check: 1. Inspect remote and make sure all buttons are working and that the bed is lifting/lowering like it should. 2. Make sure that bed rails are firmly attached to bed frame and fix as needed. 3. See if all boards are properly screwed to the frame of the bed. 4. Look for wires that are frayed or exposed and replace or remove bed so as not to be used until fixed, if necessary. When interviewed on [DATE], at 9:04 a.m. maintenance worker (M)-A stated the side rails were checked by ensuring pins were in place, the bed was snug to it, there were no gaps, and everything was tight. M-A stated he did not use a device to measure the spaces around the rails prior to the accident, but rather visually looked for gaps. M-A said this was the first air mattress that was placed during COVID-19 pandemic, and the mattress vendor was not allowed in the building to install the bed. R1's mattress came and was applied to the bed without their knowledge, therefore the bed had not been rechecked before R1 was placed into bed. When interviewed on [DATE], at 3:10 p.m. NA-C stated an air mattress arrived for R1 on [DATE], and NA-C put it together following the instruction manual that came with the mattress. NA-C placed it on R1's bed, connected it to the power and the mattress inflated. NA-C was not aware of any setting to add the patients weight, or how to check for entrapment risks. The Alternating Pressure & True Low Air Loss Mattress Replacement System Operating Instruction Manual, undated, included directions to attach the mattress and chose settings for comfort level and to use the comfort control keys to set the required patient weight position. When interviewed on [DATE], at 10:14 a.m. R1's family member (F)-E described having been told by the facility that R1 was possibly trying to get out of bed, and got stuck and died . F-E did not think R1 had the strength to do that, as staff helped R1 get in and out of bed. Lately, R1 had been more confused, but still had moments of lucidity. F-E did not recall the facility discussing any risk or benefits of siderail use with her. When interviewed on [DATE], at 9:43 a.m. the vice president of clinical support (VPCS) and the regional manager (RM) of the air mattress vendor explained how the air mattresses worked, and how they were typically set up. RM said after the accident, he was asked to visit the facility and look at all the air mattresses in the building. R1's mattress was appropriately placed and tied down at the corners. It was set at a lower pressure setting than normal, but this would not be unsafe. They normally set up the mattress for customer service, but this was not necessary. When ordering the mattress, the facility includes the bed size and patient weight and they are able to chose the correct mattress to send out. The facility would be responsible for the settings on the mattress for the resident needs, and for assessing resident safety. The immediate jeopardy (IJ) that began on [DATE], was removed and the deficient practice corrected on [DATE], when the facility took the following steps to remove the IJ and correct the deficient practice: All residents who utilized side rails were assessed for entrapment risk, many were determined to no longer be appropriate and removed on [DATE] and [DATE]. Only two residents R2 and R3 were deemed to be medically appropriate for siderail use, they were assessed for entrapment risk, risks and benefits were reviewed with resident or their representative, and physician orders [REDACTED]. The facility policy for side rail use and pressure relieving mattress use policy was updated to include a side rail assessment will be completed prior to use of a replacement mattress. A new Episcopal Church Home Side Rail Risk Benefit Agreement was created. No new mattresses would be placed prior to education of all staff on the new policy. All staff would be educated prior to working their next shift and a formal education was scheduled for all staff. The Quality Assurance Committee reviewed the incident. Observation, interviews and document review verified compliance on [DATE].