Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL289631980M
Compliance #: HL289639784C

Date Concluded: August 13, 2024

Name, Address, and County of Licensee Investigated:
River Grand Senior Living
355 River Road
Grand Rapids, MN, 55744
Itasca County

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

Evaluator's Name: Angela Vatalaro, 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 the resident when the facility failed to ensure the resident's safety with bed rail use. The resident became entrapped.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess the resident for safety risk with a hospital style bed rail until after the resident's head was entrapped between the mattress and side rail during a fall.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record, bed rail assessments, bed rail consent forms, facility internal investigation, facility incident report, and related facility policy and procedures. Also, the investigator toured the facility.

The resident resided in an assisted living facility which also had a memory care unit. The resident's diagnoses included a stroke. The resident's service plan included assistance with transferring, turning, and repositioning in bed as needed. The resident was alert and oriented.

The resident's record indicated the resident had an unwitnessed fall out of bed. The resident slid out of bed and her head was caught between the bedrail and mattress. The resident was unable to get her head out but was able to use the call pendant for staff assistance. Staff removed the resident's head from between the bed mattress and the side rail. The resident complained of left leg pain and was sent to the emergency room for evaluation. The resident was diagnosed with a hip and ankle contusion (bruise).

The resident's most current assessment for siderail safety was dated five days prior to the resident's entrapment and was completed for a grab bar, not the hospital style bed rails.

During an interview, a nurse stated because licensed staff were not made aware of the resident's new hospital bed with bed rails, licensed staff failed to assess the bedrails for resident safety. The nurse stated one night the resident fell out of bed and the resident's head was entrapped during the fall. The resident used the call pendant for staff assistance. Staff were able to get the resident's head out from between the bedrail and mattress. The resident complained of left leg pain and was evaluated at a hospital. The resident sustained a hip contusion.

During an interview, a family member stated the bed rails were hospital style bed rails that came with the resident's new hospital bed. After the incident, the facility staff spoke to the resident about removal. The resident chose not to have the bed rails removed.

During an interview, the resident said the facility nurse spoke to her about bed rails and about safety. The resident said she felt safe and had no concerns with the bed rails on her bed.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff responded to the resident's request for assistance following the entrapment and sent the resident to the emergency room for evaluation. The facility assessed the resident's hospital style bed rails and educated the resident on risk verses benefits of use. The facility offered alternatives and interventions to mitigate safety risks.

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 651-201-4200 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
Itasca County Attorney
Grand Rapids City Attorney
Grand Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28963	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GRAND SENIOR LIVING	355 RIVER ROAD GRAND RAPIDS, MN 55744

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL289639784C/#HL289631980M On June 25, 2024, 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 69 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL289639784C/#HL289631980M, tag identification 2310 and 2360.	0 000		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (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	02310		

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02310	Continued From page 1 standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with hospital style bed rails. The licensee nurse was not aware R1 had two upper hospital-style bed rails until an incident of entrapment occurred. The failure had the potential to lead to serious injury, impairment, or death. 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 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). The findings include: R1's diagnoses included cerebrovascular accident (stroke). R1's service plan dated February 5, 2024, indicated R1's services included assistance with bathing, dressing, transferring, turning/repositioning when getting in and out of bed. R1's assessment dated February 5, 2024, indicated R1 was oriented to person, place, and time, and R1's memory was "OK." R1 had a side rail (grab bar) due to left side hemiparesis (weakness). R1's bed safety assessment	02310	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 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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02310	Continued From page 2 indicated the resident used the grab bar side with turning, repositioning, and sitting upright. R1's bedrail assessment was completed when R1 had a grab bar. R1's record did not identify between the dates of February 5, and February 10, 2024, when R1 received a new device of a hospital-style bed rails. R1's incident report dated February 10, 2024, indicated R1 slid out of bed, and R1's head was caught between the mattress and bedrail. R1 used the emergency pendent to summon staff to apartment to alert staff she was unable to get head out of the bed rail. R1 complained of severe leg pain and was sent into the emergency room. R1 diagnosed with a hip contusion (bruise), no fractures were identified. The licensee's recommendation was removal of bed rails. The licensee's recommendation of removal was declined by the resident. R1's progress notes dated February 10, 2024, indicated R1 returned from the emergency room and was diagnosed with a left hip and ankle contusion. During an interview on July 3, 2024, at 1:37 p.m., registered nurse (RN)-A stated she was unaware R1 had two upper hospital style bed rails until RN-A was notified of R1's incident of entrapment on February 10, 2024. RN-A stated an assessment of the hospital style bed rail was completed after R1 became entrapped. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "The licensee is responsible for the safety and	02310		

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02310	Continued From page 3 appropriateness of all portable bed rails in the licensee's facility for residents/clients receiving assisting living/home care services. Licensees should have a process in place for monitoring and unlicensed personnel reporting new bed rails for nurse assessment. This is also true for hospital beds delivered to the licensee's facility." The licensee's policy titled Bed Rail/Device Use Policy, revised July 2022, indicated due to the risk of injury related to use of physical devices, such devices would only be used after an assessment has been completed to determine the risk and benefits of this use. Staff would be educated to report to a licensed nurse immediately of any new bed devices. Physical deceives include but are not limited to, side rails (half or full), grab bars, halo bars, or positioning poles. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 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 resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH)	02360		

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02360	Continued From page 4 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		