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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Integrated Care & Rehab	45 West 10th Street Saint Paul, MN 55102

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42586 Based on observation, interview, and document review the facility failed to ensure handwashing and appropriate glove usage was implemented for 1 of 1 resident (R9) observed for personal cares. Findings include: During observation of personal cares on 3/20/24 at 8:54 a.m., nursing assistant (NA)-A was changing R9's brief. NA-A applied gloves, used wipes to clean R9's peri area and bottom, put on a new brief and pulled up his pants. Then NA-A (without removing her gloves) removed R9's shirt, put on a new shirt, pulled the covers up to his chin, adjusted the pillow (under his head), put the bolster under the fitted sheet on his bed, and used the bed controller to put the bed in a low position. NA-A then walked out of the room (wearing the same gloves) and brought R9's shirt to the soiled utility room, removed her gloves, and used hand sanitizer. During interview on 3/20/24 at 9:05 a.m., NA-A verified she had not removed her gloves and washed her hands after changing R9's brief and should have. NA-A stated staff should always change their gloves and wash or sanitize their hands when going from a dirty area to a clean one (Ex: changing a brief to adjusting the residents pillow). During interview on 3/20/24 at 10:34 a.m., the Infection Preventionist (IP) stated staff should always remove their gloves and wash/use hand sanitizer after changing a residents depends or going from a dirty to clean area. The IP further stated if staff do not remove their gloves, they could be spreading bacteria to other residents and/or surfaces. During interview on 3/20/24 at 1:35 p.m., the director of nursing (DON) stated staff should be removing their gloves and washing their hands/using hand sanitizer after providing peri cares and then don a new pair of gloves before moving on to other areas. A facility policy on handwashing/appropriate glove usage was requested and received but it didn't address when staff should change their gloves or wash their hands when providing cares to residents.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Ebenezer Integrated Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 45 West 10th Street Saint Paul, MN 55102	

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to ensure a pressure relief air mattress was assessed for safe size in relation to the bed frame and grab bars for 1 of 1 residents (R51) reviewed for accidents. Findings include: The Guidance for Industry and Food and Drug Administration (FDA) Staff - Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated [DATE], indicated Zone 3, the space between the mattress and the bed rail, should be small enough to prevent head entrapment when taking into account the mattress compressibility, any lateral shift of the mattress or rail, and degree of play from loosened rails, and recommended a dimensional limit of less than 4 ,d+[DATE] inches (in.) for the area between the inside surface of the rail and the compressed mattress. R51's admission Minimum Data Set (MDS) dated [DATE], indicated they were cognitively intact, and had diagnoses of sepsis, muscle weakness, and encephalopathy. R51 required substantial/maximal assistance for rolling left and right in bed and was dependent on staff for transfers and toileting. R51 was at risk for pressure ulcers, had one stage II pressure ulcer, and used a pressure reducing device for their bed. The MDS indicated R51 did not use bed rails. R51's Fall Risk assessment dated [DATE], indicated they had intermittent confusion and took ,d+[DATE] medications which could impact fall risk. A Custom Medical Solutions delivery ticket dated [DATE] at 4:23 p.m., indicated a low-profile air mattress measuring 36 in. by 80 in. by 8 in. and one control unit were delivered for R51. R51's Order Summary Report dated [DATE], included an order for an air mattress to assist with wound healing starting [DATE]. R51's Fall Care Area Assessment (CAA) dated [DATE], included R51 was at risk for falls related to loss of arm or leg movement, incontinence, cognition, infection, and pain, with an objective to minimize risks. The Functional Abilities CAA indicated they required assistance with all activities of daily living (ADLs) and was dependent for all transfers. R51's care plan dated [DATE], included R51 had and ADL self-care performance deficit, required a full body lift and two staff to transfer, and assistance of two staff for repositioning and turning in bed. Their falls care plan dated [DATE], included modify environment as needed to meet current needs: Non-slip surface for bath/shower, bed in lowest position with wheels locked, floors that are even and free from spills and clutter, and provide adequate, glare-free light. The skin integrity focus revised [DATE], included R51 had an air mattress on their bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51's Device Assessment and Consent dated [DATE], indicated R51 used an air pressure mattress and bilateral grab bars to enable or enhance independence, position, or body alignment. The form identified potential risks as strangulation, suffocation, serious bodily injury, and death when residents or parts of their bodies are caught between rails/bars, in openings in the rails/bars, or between the rails/bars and the mattress. During observation and interview on [DATE] at 3:22 p.m., R51 was lying in bed with the head of the bed elevated about 40 degrees on an inflated pressure-relieving air mattress, and one grab bar was affixed to each side of the bed frame. The flat surface of the bad frame was visible one each side of the mattress, leaving an approximately four to five inches of space between the edges of the mattress and the grab bars. R51 stated they used the grab bars to assist in turning and repositioning, and staff often put pillows in the gaps. One standard bed pillow was on the chair in R51's room. The bed was identified as a Zenith 9200 Slide-W-I-D-E (adjustable up to 42 inches wide for bariatric use.) The air mattress was labeled as Matrix ALAL. During observation on [DATE] at 8:25 a.m., R51 was not present in their room. The air mattress slid side to side freely on the bed frame, allowing up to an eight-inch gap on one side and two-inch gap on the other. During observation on [DATE] at 10:28 a.m., R51 was observed asleep in bed with the gap between the air mattress and the grab bars visible on the left side. No pillows filled the gaps. During observation and interview on [DATE] at 2:40 p.m., R51 was lying on bed on the air mattress at a 35-degree angle with the air mattress pushed toward the right side of R51's bed frame. The space between the left side of the mattress and the left grab bar measured approximately eight inches, while the one on the right measure approximately two inches. During interview and observation on [DATE] at 2:42 p.m., registered nurse (RN)-B stated if a pressure-relief mattress was needed for a resident staff rented one from a vendor based upon the resident's weight and size. They stated standard sized mattresses were interchangeable with standard sized bed frames, however a bariatric frame required a bariatric mattress. They stated when the specialty mattress arrived the staff moved the resident off the original bed, the vendor placed it on the frame and demonstrated how to use it, and staff assisted the resident back to their bed. They stated air mattresses had belts to attach them to the frame, and they had never encountered a situation where a mattress did not fit. RN-B indicated side rails/grab bars could only be installed on a bed if they assisted a resident with being more independent, were assessed to be safe for the resident, and with a provider order. Upon review of R51's bed, RN-B confirmed R51's mattress was attached with straps to the bed frame; however, the mattress was free to move from side to side allowing large gaps next to the grab bars. RN-B stated the mattress configuration was a little off, was supposed to fit snugly within the rails, and could be remedied by placing a pillow tucked in the gap. They then placed a pillow in the eight-inch gap between the left side of R51's mattress and the left the grab bar. During observation and interview on [DATE] at 2:58 p.m., RN-A assessed R51's mattress and bed frame with the grab bars and confirmed the mattress and frame were not compatible. RN-A stated R51 previously used a bariatric bed and mattress, and when staff ordered the standard sized air mattress for pressure relief, they did not change out the frame. They were unsure why it was not identified sooner, and stated if R51 rolled over they could have been stuck between the mattress and the grab bar, obtained skin tears, or slid off the bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 3:02 p.m., director of nursing (DON) stated nurses completed assessments for R51's grab bars to see if there was a need or benefit, maintenance installed the brackets, and nurses or maintenance attached the rails once determined safe. They were unaware R51's mattress did not fit the bed frame and expected mattresses to be appropriate for the frame to prevent entrapment. DON stated when gaps were identified, the mattress or the bed frame should have been replaced by staff or the medical device supplier. During interview on [DATE] at 2:02 p.m., administrator stated staff checked each room and reviewed the equipment at the time of admission prior to transferring a resident into the room, and all resident bed and rails/grab bars were checked by maintenance monthly. They stated the facility had some replacement air mattresses for use, but sometimes they were rented from a medical supply company, so they were unsure who placed R51's mattress on the bed frame. They indicated if a mattress needed to be changed, they expected staff to ensure the replacement was the appropriate size, and if not, follow through by obtaining a different one, or contacting the vendor or maintenance to correct the issue to prevent entrapment concerns. During a subsequent interview on [DATE] at 10:12 a.m., administrator stated the vendor who delivered the air mattress placed it on R51's bed and did not inform the staff at the time of delivery. The Matrix ALAL Operating Instructions (undated) included entrapment may occur. Patient entrapment with bed side rails and mattress may cause injury or death. Mattress MUST fit bed frame and side rails snugly to prevent patient entrapment. Follow the manufacturer ' s instructions and monitor patient frequently. Proper patient assessment and monitoring, and proper maintenance and use of equipment is required to reduce the risk of entrapment. Variations in bed rail dimensions, and mattress thickness, size, or density could increase the risk of entrapment. Visit the FDA website at http://www.fda.gov to learn about the risks of entrapment. Refer to the owner ' s manual for beds and rails for additional product and safety information. Mattress MUST fit bed frame and bed rails snugly to reduce the risk of entrapment. The Basic American Zenith 9200 operating manual dated 2023, indicated all Basic American beds are designed in full compliance with the FDA's Hospital Bed System Guidance to Reduce Entrapment. Further, Risk of entanglement or injury may occur if the mattress used with mattress retainers does not fill the entire width between stops or which compresses to less than 1.50 inches under user's weight. Mattress must be properly sized to fit the mattress support platform and must remain centered on the support platform relative to State and Federal guidelines. Length and width should match the mattress support platform. Use of an improperly fitted mattress could result in injury or death. IMPORTANT: Powered air mattress surfaces may pose a risk of entrapment. Prior to use, ensure the therapeutic benefits outweigh the risk of entrapment. The document indicated patients at high risk for entrapment include those with confusion, lack of muscle control, and altered mental status due to medication. The facility Adaptive Equipment policy dated [DATE], indicated mattresses must fit snug against the bed frame, and the distance between the rail and the mattress was not to exceed 4.75 inches.