Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282278004M
Compliance #: HL282274122C

Date Concluded: April 8, 2025

Name, Address, and County of Licensee Investigated:
Oak Park Senior Living
13936 Lower 59th Street North
Oak Park Heights MN, 55082
Washington County

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

Evaluator's Name: Kris Detsch, 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 staff failed to provide supervision, as a result, the resident remained pinned between the bed frame and side rail for two days and sustained injuries.

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's mobility devices, including the bed rail he used because nurses did not complete assessments in the resident's room and did not verify information "carried over" from a previous assessment was still accurate and current. The resident fell, became entrapped in the device, unable to use his call pendant and was stuck for a prolonged amount of time that ceased circulation to his arm and caused rhabdomyolysis (a life-threatening condition from muscle tissue breakdown by being in a position for a prolonged period of time and release of body toxins into the bloodstream). The resident died of complications from entrapment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted home care agencies and an emergency responder. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, and related facility policy and procedures. Also, the investigator toured the facility and observed staff providing safety checks and observed resident rooms.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, asthma, and high blood pressure. The resident had a history of falling. Initially the resident moved into the facility after he fell and sustained a hip fracture. During this time, he required extensive help from staff. The resident recovered from his injury and required less help so he moved to a different apartment within the facility.

The resident's service plan included assistance with weekly housekeeping, twice weekly showers, and one daily safety check scheduled at 10:00 a.m. The resident's nursing assessment indicated he was independent with mobility but required an electric wheelchair. The resident was alert and orientated, but forgetful.

Multiple nursing assessments completed by facility nurses included the same information carried over from the previous assessment that was inaccurate to the resident's present condition. The assessments inaccurately indicated several wounds what were long healed, although the resident received twice weekly showers. The assessments indicated the resident's assistive devices included glasses, a walker and a shower chair. The assessments indicated the resident had a bed rail. The assessment directed if indicated "yes" to the resident having a bed rail, to complete a bed rail assessment. The facility nurses failed to assess the bed rail to determine if it was consistent with regulatory safety requirements and the resident used it safely. A facility nurse completed a nursing assessment fifteen days prior to the resident's entrapment in the bed rail.

Photo images of the bed rail showed a device that was "U" shaped with adjustable metal sides.

An incident report indicated at 3:00 p.m., unlicensed personnel (ULP) #1 went into the resident's room to give him his shower. ULP #1 found the resident on the floor with his right arm wedged between his bed and bed rail; his feet pinned by his motorized wheelchair.

A law enforcement report indicated law enforcement responded to a 911 call with the resident stuck in his bed rail. The resident told officers he had been stuck for two days. Law enforcement assisted paramedics with removing the bed rail to free the resident. Paramedics transported the resident to the hospital.

Hospital records indicated the resident had pressure injuries to his right shoulder, and the back of his right knee from entrapment in the bed rail. The resident developed sepsis (life

threatening infection) from skin infection and rhabdomyolysis which caused kidney failure. He died four days later.

Medical examiner report indicated the resident died from complications of prolonged partial entrapment in bed rail. The medical examiner report indicated prolonged down time with rhabdomyolysis was a significant condition contributing to the resident's death.

Photo images of the resident in the hospital showed the resident had dark purple bruising on his right arm, around his elbow. He had dark purple bruising and swelling on his right hand. He had linear pattern redness and dark purple bruising from his right armpit to his chest. His left leg had a laceration to his left shin and toes with bright red blood. His right knee showed he had dark purple bruising on his kneecap and dark purple bruising just below his kneecap on the outside of his leg. This bruising appeared to extend toward the back of his leg.

ULP #1 failed to respond to requests for an interview, however provided a written statement to the facility. In her statement ULP #1 said she entered the resident's apartment to give him a shower shortly after 3:00 p.m. and saw him sitting on the floor by his bed. The resident told her no one checked on him for two days. ULP #1 said the resident spoke in "jumbled" sentences. ULP #1 called for help from ULP #2 who then sat with the resident while she called the nurse. ULP #1 said the resident's motorized wheelchair was on top of his feet, so ULP #2 removed the wheelchair and saw a deep cut to his left shin. ULP #1 said the resident looked like he was trying to get from his chair into his bed when he fell. ULP #1 said the resident was confused and looked exhausted. ULP # 1 called 911 and let them into the facility. ULP #1 said the emergency responders asked her when the last time staff members checked on him prior to the fall. ULP #1 told emergency responders the resident was supposed to get a safety check in the morning, however ULP #3 was supposed to do the resident's safety check, but she did not always complete required safety checks.

During an interview, ULP #2 said the resident was sitting on the floor with his wheelchair on top of his lower legs, and his right arm was through the bed rail. ULP #2 said the resident's call pendant was around his neck, but he could not get at it because his arm was stuck in the bed rail. ULP #2 said it looked as though the resident was trying to get out of bed, and slid down, but he also could have been trying to get into bed so she could not determine what occurred. ULP #2 said the resident "screamed" he had been there for two days. ULP #2 said she asked ULP #3 when she saw him last and ULP #3 told her she saw him at 8:30 a.m., sitting at his table.

ULP #3, failed to respond to requests for an interview, but did provide a written statement to the facility. In her statement ULP #3 said she saw him around 8:00 a.m. or 8:30 a.m. and he used his "grabber" to crack his door open. ULP #3 said he was sitting in his wheelchair.

During an interview, an emergency responder said the resident was sitting on the ground with his right arm "looped" between the bed rail and mattress and his back was against the bed frame. The emergency responder described the bed rail as a "U" shaped device not attached to

the bed frame. The emergency responder said they (with law enforcement) had to remove the bed mattress to free the resident from entrapment. Once they removed the mattress, the bed rail slid out from the bed frame. The resident's right arm had a "visible" pressure injury (skin damage). The emergency responder said the resident also had pressure injuries to his back from the bed frame. The emergency responder said the resident did not have a pulse in his right wrist and his blood pressure was very low. The emergency responder said the resident was alert but confused. The resident told the emergency responder he had been on the ground for two days.

During an interview, a manager said she saw the resident the day prior to the fall at lunch time and had a conversation with him. The resident did not go to dinner in the evening, but this was not unusual behavior for him. The manager said she spoke to ULP #3 who told her she completed a safety check between 8:00 a.m., and 9:00 a.m. the morning the incident occurred and gave the facility a written statement with the same information. The manager asked ULP #1 how she determined ULP #3 did not complete residents' safety checks, but ULP #1 did not give her a clear answer. The manager said ULP #1 did not work on the same shift as ULP #3. The manager said the facility changed their safety check procedure after this incident. The facility residents must now place their own initials on a piece of paper when staff members complete their safety check. The manger said the facility staff were unaware the resident had a bed rail.

During an interview, a facility nurse said the facility's computer system "carried over" answers and information from prior nursing assessments, therefore the nurse completing an assessment, must go into the current assessment and change information based on their observation of the resident. If they do not change the information, prior information remains on the assessment. The nurse said she completed the resident's nursing assessment in an office, not his apartment, so she did not observe his room or the bed rail. The nurse acknowledged her nursing assessment indicated the resident used a bed rail; however, said the documentation was a mistake. The nurse said, since this incident, nurses complete room checks during their nursing assessments and observe for bed rails, or environmental hazards.

During an interview, a family member said the resident's assistive devices included use of a walker, manual wheelchair, electric wheelchair, over-the toilet commode, a bath bench and a four wheeled walker with a seat. The family member stated he thought the resident had the bed rail for over a year. The resident used the bed rail to hold his wedge pillow in place to keep him in an upright position for better breathing while sleeping. The family member said staff were in the resident's room daily and did not tell him he could not use the bed rail. The family member said they were concerned the resident did not receive his morning safety check.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility changed their procedures for safety checks and nursing assessments.

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.

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
Dakota County Attorney
Oak Park Heights City Attorney
Oak Park Heights Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28227	A. BUILDING: _____ B. WING _____	C 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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: HL282274122C/HL282278004M On March 12, 2025, 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 132 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order orders are issued for HL282274122C/HL282278004M , tag identification 620, 1620, 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 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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for one of one resident (R1) with records reviewed. The licensee was aware R1 was entrapped in his bed rail and died because of the medical complications from the incident, but failed to immediately report the incident to the Minnesota Adult Abuse Reporting Center (MAARC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 620		

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0 620	Continued From page 3 The findings include: R1 admitted to the licensee on April 1, 2023, for diagnoses including a hip fracture with surgical repair, and asthma. R1's assisted living contract dated August 18, 2023, indicated R1 moved to a different apartment within the licensee's building, considered to be "independent living". R1's individualized service amendment dated August 23, 2024, indicated R1 received housekeeping every Thursday, an "I'm OK check" (safety check) every day at 10:00 a.m., and shower assistance twice weekly (Wednesday and Saturday). R1's incident report dated December 28, 2024, at 3:00 p.m., indicated unlicensed personnel (ULP)-I went into R1's room to give him his shower. ULP-I found R1 on the floor with his right arm wedged between his bed and bed rail and his feet pinned by his motorized wheelchair. R1 was confused. The incident report indicated ULP-I called the facility nurse at 3:08 p.m., then called emergency responders (911) at 3:12 p.m.. Law enforcement report dated December 28, 2024, at 4:39 p.m., indicated a law enforcement responded because R1 fell and was "stuck" in his bed rail. R1 told law enforcement, several times, he had been stuck there for two days. R1 told law enforcement he requested staff to check on him prior to this occurring. Law enforcement assisted the paramedics with removing the bed rail, and freeing R1. Paramedics took R1 to the hospital. The report indicated the licensee's staff members did not know when R1 fell. One staff member told law enforcement she heard the staff member who	0 620		

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0 620	Continued From page 4 was supposed to make daily checks does not actually perform them. The report indicated law enforcement was concerned about the events and called the licensee's licensed assisted living director (LALD)-A. Law enforcement records dated December 29, 2024, at 2:14 p.m., indicated law enforcement spoke to LALD-A, and she told them she saw R1 on December 27, 2024, at lunch time. LALD-A told law enforcement a staff member said they saw R1 on December 28, 2024, at around 10:00 a.m. LALD-A said she would continue to follow up with other staff members to verify if they completed safety checks. Medical examiner cause of death worksheet dated January 3, 2025 (filing date), indicated R1 died on December 31, 2024, from complications of prolonged partial entrapment in bed side rail. R1's progress notes dated January 7, 2025, at 8:44 a.m., indicated R1 died on December 31, 2024. On March 3, 2024, at 10:10 a.m., the surveyor reviewed the licensee's MAARC reports. The licensee's records failed to include a report for R1. LALD-A said the licensee did not complete a MAARC report because R1 was "independent living." LALD-A said "corporate" made the decision not to report the incident. The licensee's policy titled, Vulnerable Adult Maltreatment- Prevention and Reporting, dated August 1, 2021, indicated the licensee would comply with the Minnesota Vulnerable Adults Act and Assisted Living licensure regulation. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		

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01620 SS=J	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record reviewed the licensee failed to complete accurate, comprehensive nursing assessments to include assistive devices for one of one resident (R1) with records reviewed. The licensee "carried over" documentation from previous records, and failed to update R1's clinical record to reflect an accurate assessment of his assistive devices, and medical needs. R1's bed contained a bed rail the licensee failed to identify as required by	01620		

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01620	Continued From page 6 Minnesota (MN) Rules 4659.0150. The bed rail was not consistent with regulatory standards and R1 became entrapped in the side rail and died from complications of prolonged entrapment. This practice resulted in a level four violation (a violation that results in 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 admitted to the licensee on April 1, 2023, for diagnoses including a hip fracture with surgical repair, and asthma. R1's nursing assessment dated December 13, 2024, indicated he was independent with dressing, toileting, transfers and mobility, but required assistance with showers. R1 was forgetful and at risk for falling, and was afraid of falling. R1's assisted living contract dated August 18, 2023, indicated R1 moved to a different apartment at the facility, considered to be "independent living." R1's individualized service amendment dated August 23, 2024, indicated R1 received housekeeping every Thursday, an "I'm OK check" (safety check) every day at 10:00 a.m., and shower assistance twice weekly on Wednesday and Saturday. Nursing Assessments: The following nursing assessments contained	01620		

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01620	Continued From page 7 duplicate/unchanged information and inaccurate to R1's present condition and needs at the time of the assessment. R1's nursing assessment dated June 28, 2024, indicated registered nurse (RN)-C completed a "face to face" assessment. The assessment indicated this was a routine (required) 90-day nursing assessment. The nursing assessment form included a section for "assistive devices." This section listed R1's assistive devices: glasses, walker, and shower chair. RN-C did not list any further devices in this section. The same nursing assessment contained a "vulnerabilities" section. Under this section, directed if the resident had a side rail (bed rail) to complete a side rail assessment under assessment upon admission, every 90 days and PRN (as needed). RN-C indicated "yes" to R1 having a side rail. The nursing assessment failed to include a side rail assessment. The nursing assessment included a section for a skin assessment. RN-C documented R1 had bilateral lower extremity edema at stage four (pitting edema) with weeping (draining) areas and discoloration of the skin. R1 had wounds to his coccyx and right heel. The documentation indicated R1 received wound care from a wound care agency. On March 24, 2025, at 9:02 a.m., the surveyor spoke to the wound care agency listed in R1's nursing assessments as responsible for providing wound care to R1's wounds. The wound care agency stopped providing services to R1 on July 28, 2023, almost one year prior the completion of the nursing assessments provided to the surveyor. R1's nursing assessment dated September 26, 2024, indicated director of nursing (DON)-G	01620		

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OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
01620	Continued From page 8 completed a "face to face" assessment. The assessment indicated this was a routine (required) 90-day nursing assessment. The nursing assessment form included a section for "assistive devices." This section listed R1's assistive devices: glasses, walker, and shower chair. DON-G did not list any further devices in this section. The same nursing assessment contained a "vulnerabilities" section. Under this section, directed if the resident had a side rail to complete a side rail assessment under assessment upon admission, every 90 days and PRN (as needed). DON-G indicated "yes" to R1 having a side rail. The nursing assessment failed to include a side rail assessment. The nursing assessment included a section for a skin assessment. DON-G documented R1 had bilateral lower extremity edema at stage four (pitting edema) with weeping (draining) areas and discoloration of the skin. R1 had wounds to his coccyx and right heel. The documentation indicated R1 received wound care from a wound care agency. R1's nursing assessment dated December 13, 2024, indicated RN-C completed a "face to face" assessment. The assessment indicated this was a routine (required) 90-day nursing assessment. The nursing assessment form included a section for "assistive devices". This section listed R1's assistive devices: glasses, walker, and shower chair. RN-C did not list any further devices in this section. The same nursing assessment contained a "vulnerabilities" section. Under this section, directed if the resident had a side rail to complete a side rail assessment under assessment upon admission, every 90 days and PRN (as needed). RN-C indicated "yes" to R1 having a side rail. The nursing assessment failed to include a side rail assessment. The nursing assessment included a	01620		

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01620	Continued From page 9 section for a skin assessment. RN-C documented R1 had bilateral lower extremity edema at stage four (pitting edema) with weeping (draining) areas and discoloration of the skin. R1 had wounds to his coccyx and right heel. The documentation indicated R1 received wound care from a wound care agency. On March 20, 2025, at 9:05 a.m., a family member (FM)-H said R1's assistive devices included a walker, wheelchair, electric wheelchair, over the toilet commode, a bath bench, and a four wheeled walker with a seat. FM-H said he was unsure how long the side rail was installed on R1's bed, but thought it was over a year. FM-H said there was only one side rail, on R1's bed. FM-H said R1 used it to hold his "wedge" pillows in place, to keep him in an upright position so he could breathe better when he slept. FM-H said initially R1 required more mobility assist because he fell and fractured his hip. R1 required a higher level of assistance. FM-H said the licensee told the family R1 could not have a side rail, so family removed it. FM-H moved into a different apartment and required less care and used the side rail again. FM-H said the licensee never told them R1 could not use a side rail when R1 lived in the "independent" apartment. FM-H said the licensee's staff were in R1's room daily and did not tell them he could not use it. On March 25, 2025, at 12:02 p.m., FM-F provided the surveyor the name of the home care agency who provided wound care to the resident during the time of the incident. The home care agency was not located on the nursing assessments, or R1's other documentation. On March 28, 2025, at 9:23 a.m., case manager (CM)-K said she provided wound care and INR	01620		

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01620	Continued From page 10 (international normalized ratio, blood clotting time) blood draws to R1. CM-K said R1 started services with her agency on December 3, 2024. CM-K said R1's last visit was on December 27, 2024. CM-K said R1 had one wound to his toe, no other wounds. Incident: R1's incident report dated December 28, 2024, at 3:00 p.m., indicated unlicensed personnel (ULP)-I went into R1's room to give him his shower. ULP-I found R1 on the floor with his right arm wedged between his bed and bed rail and his feet pinned by his motorized wheelchair. R1 was confused . Law enforcement report dated December 28, 2024, at 4:39 p.m., indicated a law enforcement responded because R1 fell and was "stuck" in his bed rail. R1 told law enforcement, several times, he had been stuck there for two days. R1 told law enforcement he requested staff to check on him prior to this occurring. Law enforcement assisted the paramedics with removing the bed rail, and freeing R1. Paramedics took R1 to the hospital. Hospital records dated December 28, 2024, at 5:33 p.m., indicated when R1 arrived into the emergency room, his right arm was mottled (skin discoloration) and had a weak radial pulse. R1 had a non-blanchable (skin discoloration) area to his right shoulder and limited mobility in his right arm. Hospital records dated December 31, 2024, at 8:37 p.m., indicated R1 had pressure injuries to his right shoulder and back of his right knee from being entrapped in a bed rail. The records indicated R1 developed sepsis (life threatening infection) from cellulitis (skin infection), and	01620		

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01620	Continued From page 11 rhabdomyolysis (breakdown of muscle tissue that releases damaging protein into the blood stream) which resulted in kidney failure. R1 died at December 31, 2024, at 5:38 p.m. Medical examiner cause of death worksheet dated January 3, 2025 (filing date), indicated R1 died on December 31, 2024, from complications of prolonged partial entrapment in the side rail. On March 12, 2025, at 1:16 p.m., licensed assisted living director (LALD)-A said she took DON-G to R1's room the following day to determine what occurred. LALD-A said the side rail was off R1's bed, and on the floor. LALD-A described the side rail as being approximately a foot and one-half wide, and two feet high, rounded at the top. LALD-A said she did not know how the side rail was secured to the bed frame. LALD-A said she and DON-G were unaware R1 used a siderail. LALD-A said the licensee has a record of all residents who use a side rail and every month, the licensee's maintenance department checks them. LALD-A said DON-G told staff members to alert nursing staff when they see new side rails on any resident's bed. On March 14, 2025, at 3:19 p.m., RN-C said nursing assessments contain information from the previous assessment, then the nurse who completes an assessment is required to go into the assessment and change information based on their assessment of the resident. RN-C said she did not go into R1's bedroom and her documentation might have been a mistake. RN-C said if she noticed the side rail, she would have completed the required side rail assessment. RN-C said the licensee now requires nurses to go into the resident's room to check for side rails, safety hazards, or new changes to their	01620		

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01620	Continued From page 12 environment when they complete their nursing assessments. On March 19, 2025, at 1:05 p.m., DON-G said R1 was independent and only required staff to assist him with weekly showers, and daily "I'm OK checks." DON-G said she was not aware R1 had a side rail on his bed. DON-G said when she looked at the side rail (after the incident), she determined the side rail did not meet regulatory guidelines, and the licensee would not have allowed R1 to use it. DON-G said the licensee had not completed any required side rail assessments. DON-G said the nursing assessments indicated he had a side rail was likely information from a prior assessment that carried over to each nursing assessment. The FDA's "A Guide to Bed Safety," revised April 2010, indicated, "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 determine how best to keep the patient safe." Minnesota (MN) Rules 4659.0150, Subpart 1-3, indicated the uniform assessment tool used by licensee to comprehensively evaluate a resident (nursing assessment) must include the resident's use of assistive devices. The licensee's policy titled, Assessments, Reviews, and Monitoring, dated, August 1, 2022,	01620		

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01620	Continued From page 13 indicated the licensee's nursing assessments would include all elements of the uniform assessment tool. Time period for correction: Seven (7) days	01620		
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(s) reviewed (R1) was free from maltreatment. Findings include: 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		