State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273893282M **Date Concluded:** July 5, 2024
Compliance #: HL273893389C

Name, Address, and County of Licensee Investigated:
Beacon Home of Rosemount
12591 Shannon Parkway
Rosemount. MN, 55608
Dakota County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Peggy Boeck
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):

Allegation #1: The facility neglected Resident 5, (R5) when the facility failed to process and implement orders for staff removal of R5's leg brace during the day. R5 acquired two pressure ulcers on her ankle under the brace.

Allegation #2: The facility neglected Resident 1 (R1), R2, and R5, when the facility was aware the residents siderails were not assessed for safety and were being utilized inappropriately. The facility failed to follow up to ensure the residents safety despite the awareness of the safety concerns with the R1, R2, and R5's siderails.

Investigative Findings and Conclusion:
Allegation #1: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility neglected to process orders for removal of R5's leg brace during the day, so staff left it on all day, which created pressure on

the ankle skin, and R5 acquired two pressure ulcers. The facility failed to complete timely, accurate, skin checks/assessments, and nursing failed to follow-up on refusals.

Allegation #2: The Minnesota department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to implement a system to obtain orders, conduct appropriate assessments, monitor, and maintain bed rails per manufacturer and FDA guidance. Significant risk occurred of the potential for death by entrapment of R1, R2, and R5.

The facility contracted with a consultant company to assist with correcting orders issued during a previous investigation and the subsequent conditional licensure placed by the Minnesota Department of Health (MDH).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of the residents' records, facility incident reports, nurse consultant reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed and tested the security of R1, R2, and R5's bed rails, which all had significant movement, thus increasing the zones of entrapment.

Allegation #1:

R5 lived at the assisted living facility due to diagnoses that included dementia, blindness, and a history of stroke with left side weakness. R5 required a left foot/leg brace for stability with transfers.

R5 reported discomfort from the left leg brace but there was no documented follow up by the nurse. The consultant expressed concerns to the facility of the lack of timely, accurate skin checks/assessments. Three months after the initial complaint of pain, a nurse noted a reddened area on R5's left ankle and reported it to the medical provider, who ordered removal of the brace for up to 60 minutes at a time while R5 sat in the wheelchair or in bed during the day.

The consultant discovered that the order was never processed into the service plan, so unlicensed staff were not aware and did not remove the brace as noted in the order. The consultant expressed concern to the facility for several weeks that nursing did not follow-up with residents who refused skin checks, as R5's record twice indicated "no areas of concern" and once indicated "skin healed" while the pressure ulcer still existed. The consultant then noted that the staff were not removing R5's brace per the service plan once it was added, and R5 developed another pressure ulcer.

During an interview, a nurse stated R5's foot brace had recently been adjusted, so it no longer pressed on the ankle. The nurse stated staff could still remove the brace to give the skin a break but confirmed that direction was not in R5's service plan.
R5's wounds healed.

Allegation #2:

R1 lived at the assisted living facility due to diagnoses that included dementia and epilepsy. Resident 1 had a history of falls. R1 received services from the facility that included safety checks of bed rails by unlicensed personnel, ensuring it was secured to the bed frame and flush [defined as: fitting snugly or evenly next to] the mattress. The service plan directed unlicensed personnel to notify a nurse if the bed rail was loose or damaged.

R2 lived at the assisted living facility due to diagnoses that included a stroke with left side paralysis. R2's assessment indicated the resident was weak and had a balance deficit. Documentation indicated unlicensed personnel completed safety checks of R2's bed rails to ensure the presence of "pool noodles" between the mattress and bed rail, and to ensure the bed rail was secured to the bed frame and flush with the mattress. The service plan directed unlicensed personnel to notify a nurse if the bed rail was loose or damaged.

R5 lived at the assisted living facility due to dementia and blindness. R5 had a history of falling from the bed and expressed severe anxiety of a fall happening again. R5's service plan included safety checks of bed rails. The plan directed unlicensed personnel to place "foam noodles" in the four corners of the bed, and to ensure the bed rails were secured to the bed frame and flush with the mattress. The service plan directed staff to report loose or damaged bed rails to a nurse.

The consultant expressed concerns to the facility regarding bed rails in reports dating back five months. The consultant provided direction regarding updating their bed rail assessment to include regular monitoring and measuring zones of entrapment (areas between the bed rail and the mattress that could trap a resident's head/neck causing death). The consultant directed the facility to manufacturer's guidelines and noted the high risk.

The facility failed to measure the mattresses heights and widths to ensure they were compatible with the bed frames per bedframe manufacturer's guidance.

The facility failed to regularly inspect the mattresses and bed rails to ensure still correctly installed and failed to regularly measure between the bed rails and mattress, ensuring there was no gap wide enough to entrap a resident's head or body.

During an interview, a nurse stated staff checked the bed rails, to ensure they were not falling off, and were secured to the bed frame. The nurse stated staff had not informed her of any loose bed rails and they would not document if they had. The nurse reviewed video taken by the MDH investigator showing the significant movement of R1, R2, and R5's bed rails, but offered no opinion as to whether the bed rails were safe.

During investigative interviews, multiple staff members stated they did not check the bed rails, but if they saw that they were falling off they would probably tell a nurse.

During an interview, R5's family member stated the facility neglected the resident when they removed the original bed rails without warning (replacing them with smaller grab bars [Halo]) and failed to provide an appropriate bed for the resident that would lower all the way to the floor. The family member stated the resident experienced extreme anxiety over falling out of bed. The family member stated the facility placed a "crash mat" next to the resident's bed to decrease the extent of injury if the resident fell, and stated a wider mat would increase his comfort level.

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 processed R5's order for brace removal and monitored R5's skin. The facility instituted a policy for interventions for resident refusals of skin checks.

The facility replaced R1 and R5's side rails with Halo grab bars. The facility removed one of R2's side rails.

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
Rosemount City Attorney
Rosemount Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27389	A. BUILDING: _____ B. WING _____	C 05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HOME OF ROSEMOUNT	12591 SHANNON PARKWAY ROSEMOUNT, MN 55068

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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: #HL273893389C/#HL273893282M On May 20, 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 four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL273893389C/#HL273893282M tag identification 2310 and 2360.	0 000		
02310 SS=I	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 observation, interview, and document review, the licensee failed to provide care and services according to acceptable heath care, medical, or nursing standards for three of three residents (R1, R2, and R5) who utilized bedrails. Potential for harm occurred when the facility failed to ensure bed rails were assessed, ordered, and maintained per the Food and Drug Administration (FDA) and manufacturer's guidelines for R1, R2, and R5. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: During observation of rooms of residents who utilized bed rails on May 20, 2024, the Minnesota Department of Health (MDH) investigator observed and captured video of the following: R1's bed had "Halo safety rings" attached near the head of the bed on each side. The bed rails were both loosely attached, wobbled from side to side and back and forth, which increased the gap in FDA Zone of Entrapment #3 (the area between the bed rail and the mattress). The investigator observed pool noodles tucked under a fitted sheet on both sides of the bed.	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 R2's bed had a full side rail on the left side of the bed (viewing from foot of bed to head of bed). The bed rail was loosely attached, wobbled from side to side and back and forth, which increased the gap in FDA Zone of Entrapment #3. The investigator observed a pool noodle tucked under a fitted sheet on the left side of the bed. R5's bed had "Halo safety rings" attached near the head of the bed on each side. The rails were both loosely attached, wobbled from side to side and back and forth, which increased the gap in FDA Zone of Entrapment #3. R1 R1 moved into the facility on March 22, 2022, due to diagnoses that included traumatic brain injury, dementia, and epilepsy. R1's Hennepin County court guardianship order dated November 12, 2021, indicated R1 experienced poor memory and a deteriorating mental state with confusion, impulsivity, and inability to cooperated with medical decision making. R1's "Functional Assessment for those who have a Bedrail" documents dated January 8, 2024, and March 8, 2024, indicated R1's conditions contributing to use of a bedrail included weakness. The assessments indicated "Yes" to the following: "1 FDA gap open space under the rail, between rail supports, or next to a single rail support is less than 4.75 inches". "2 FDA gap between rail and mattress is less than 4.75 inches." "3 FDA gap between rail and mattress is less than 4.75 inches." "4 FDA open space between the bottom of the rail and mattress is less than 2.375 inches."	02310		

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02310	Continued From page 3 The assessment did not indicate the actual measurements of the mattress or zones of entrapment. R1's service plan dated May 20, 2024, indicated R1 received services from the licensee including safety checks of bed rails, which directed unlicensed personnel (ULP's) "checking the bed rail to assure it was secured to the bed frame and flush with the mattress". The service plan directed ULP's to report loose or damaged rails to the nurse. R2 R2 moved into the facility on September 1, 2022, due to diagnoses that included a stroke with weakness/paralysis on her left side. R2's "Functional Assessment for those who have a Bedrail" documents dated January 2, 2024, and March 18, 2024, indicated R2's conditions contributing to the use of a bedrail included weakness. The assessments indicated "Yes" to the following: "1 FDA gap open space under the rail, between rail supports, or next to a single rail support is less than 4.75 inches". "2 FDA gap between rail and mattress is less than 4.75 inches." "3 FDA gap between rail and mattress is less than 4.75 inches." "4 FDA open space between the bottom of the rail and mattress is less than 2.375 inches." The assessments did not indicate the actual measurements of the mattress or zones of entrapment. The assessment indicated "per policy halo side rails are required." R2's service checkoff lists dated April 1, 2024,	02310		

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02310	Continued From page 4 through May 20, 2024, directed ULPs to "ensure [pool] noodles are in place between mattress and bed rails. Unlicensed assistive personnel to check the bed rail to assure it is secured to the bed frame and is flush with the mattress." R2's service plan dated and provided to the MDH investigator on May 20, 2024, contained no services or interventions regarding bed rails. R5 R5 moved into the facility on June 18, 2019, due to diagnoses that included dementia, bilateral hearing loss, stroke, and cortical blindness. R5's "Provider Orders" document dated January 3, 2024, indicated the provider approved bilateral halo bed rails. R5's service check off dated April 2024, indicated staff were to "ensure the 4 foam noodles are secured in the correct place of each corner of the bed between the head/foot boards and side rails." R5's "Functional Assessment for those who have a Bedrail" document dated May 7, 2024, indicated R5's conditions that contribute to R5's use of a bedrail included weakness, fear of rolling out of bed, and history of falling out of bed. The assessment indicated "Yes" to the following: "1 FDA gap open space under the rail, between rail supports, or next to a single rail support is less than 4.75 inches". "2 FDA gap between rail and mattress is less than 4.75 inches." "3 FDA gap between rail and mattress is less than 4.75 inches." "4 FDA open space between the bottom of the rail and mattress is less than 2.375 inches." The assessment did not indicate the actual	02310		

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02310	Continued From page 5 measurements of the mattress or zones of entrapment. No other assessments for bedrails for R5 dated before or after May 7, 2024, were provided to the MDH investigator. During an interview on May 20, 2024, at 10:00 a.m. unlicensed personnel (ULP)-A stated the staff do not check bed rails. ULP-A observed/verified, with the MDH investigator, the placement and security of the bed rails on R1's, R2's, and R5's bed. ULP-A confirmed all three residents (R1, R2, and R5's) bed rails were loose and wobbly. During an interview on May 20, 2024, at 10:45 a.m. licensed practical nurse (LPN)-B stated if a resident had bed rails, there should be an intervention in the resident's service plan for staff to make sure the bed rails are secure. LPN-B stated Halo type bed rails did not have to be measured (for zones of entrapment). During an interview on May 20, 2024, at 11:15 a.m. registered nurse-director of nursing (RNDON)-C stated she believed the bed rail assessment document contained measurements. RNDON-C stated no staff had reported any bed rails as loose or wobbly, but the facility did not require staff to document if they did report. RNDON-C stated, after viewing MDH investigator video of bed rail movements, that she could not give an opinion if the bed rails seen on the videos would be safe for a resident. RNDON-C stated she would have to look at the FDA guidelines. Consultant Conditional Licensure Report dated March 8, 2024, indicated the facility contracted with their company on October 25, 2023, for consulting services to assist with correction	02310		

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02310	Continued From page 6 orders and subsequent conditional licensure from an investigation concluded on September 20, 2023. The nurse consultant indicated the only progress note regarding R5's bed rails was from December 29, 2023, and she could not locate further documentation on R5's bed rails. The report indicated the nurse consultant again discussed the responsibility of LPN-B or RNDON-C to follow-up on orders with medical equipment companies and the provider regarding R2 and R5's bed rails. Consultant Conditional Licensure Report dated March 15, 2024, indicated the nurse consultant could not locate further documentation on R5's bed rails. The nurse consultant again noted the last progress note regarding R5's bed rails was dated December 29, 2023. The report indicated LPN-B said the facility received an updated order for R5's bed rails, but still needed a current face to face assessment. The nurse consultant indicated the order could not be located. The report indicated the nurse consultant spoke with LPN-B about R2's bed rails, who indicated the facility was waiting for R2's case manager to approve the cost of the bed rails and to see if the bed rails could be paid for by the Elderly Waiver. Consultant Conditional Licensure Report dated March 22, 2024, indicated the nurse consultant found an order for R5's hospital bed, but no order for the bed rails. The report indicated R2 continued to have a full side rail (on the left side of the bed). The report indicated LPN-B said she last followed up on payment of R2's bed rails on March 1, 2024, but the medical record contained no documentation of an update. The report indicated R1 had Halo bed rails, but there was no doctor's order.	02310		

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02310	Continued From page 7 Consultant Conditional Licensure Report dated April 5, 2024, indicated the nurse consultant spoke with LPN-B with concerns of the delay in communication with resident's doctor and suppliers regarding bed rails. LPN-B stated the licensee would not pay for Halo bed rails. The report indicated R5 had full bed rails (extending from the head of R5's bed to the foot of R5's bed) and reviewed documentation of LPN-B's attempts to get R5's insurance to pay for a new hospital bed, and LPN-B's efforts to obtain approval of the Elderly Waiver to pay for these items for R5. Consultant Conditional Licensure Report dated April 12, 2024, indicated the nurse consultant observed R5's bed had full bed rails on both sides, with no further documentation of when side rails will be replaced with "FDA approved assist bars". The report indicated the nurse consultant observed that R2 had one bed rail, and that the facility removed the other bed rail "because it was loose". The report indicated there was no further documentation of when R2's side rails would be replaced with "FDA approved assist bars". Consultant Conditional Licensure Report dated April 19, 2024, indicated the nurse consultant reviewed R1's medical record which indicated R1 had Halo bed rails on his bed. The nurse consultant reviewed R1's "Functional Assessment for those who have a Bed" rail document dated 1/8/24. The nurse consultant did not locate documentation in the progress notes or bed rail assessment what was discussed in regard to risk/benefit, which was marked as "Yes" that RNDON-C "explained the risk/burden/benefit" of bed rails. The report indicated R1 had no service in his Service Plan for the Halo bed rail to be checked for safety, and that R1's record lacked a doctor's order for the bed rail. The report	02310		

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02310	Continued From page 8 indicated R2's record also lacked documentation of what risks/burden/benefit were discussed. The report indicated R2's service plan had a service for ULPs to check R2's bed rail to "ensure that the noodles are in between mattress and bedrails" and to "check the bed rail was secured and flush with the mattress". The report indicated R5 had two full bed rails and the Functional Assessment for those who have a Bedrail indicated that zones #3, #4, #6, and #7 had a gap between R5's bed rail and mattress. The assessment indicated a "foam noodle added to meet zone". The report indicated R5's record lacked documentation of content of discussion of risk/burden/benefit. The report indicated R5's service plan included a service for ULPs to "ensure the 4 foam noodles are secured in the correct place of each corner of the bed between the head/foot boards and side rails" and to check the bed rail was secured and flush with the mattress. The report indicated R5's record lacked evidence of a doctor's order for full bilateral bed rails. Consultant Conditional Licensure Report dated April 26, 2024, indicated R2's medical record lacked documentation of communication between the facility nurse and R2's case manager requesting a new face to face assessment, documentation of the face-to-face assessment, and doctor's orders for bed rails. The report also indicated R5's medical record lacked documentation of a face-to-face assessment. The report indicated LPN-B reported she contacted R2's case manager who requested a new doctor's order for bed rails and a new face to face assessment due to the age of the previous order, but the nurse consultant could find no documentation of the conversation. The report indicated the nurse consultant had repeatedly	02310		

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02310	Continued From page 9 recommended nursing presence at the facility five days per week to follow-up with continued areas of concern as the systems in place were not effective. The report indicated the assisted living director discontinued the nurse consultant relationship and would seek a new nurse consultant service. The Weekly Summary Report document dated April 30, 2024, indicated the facility contracted with a new consulting company to help guide them and assist with correcting the deficiencies and aligning their practices with Minnesota Statutes. The report listed action items for the facility to complete prior to nurse consultant's next visit. The items included review of licensed practical nurse (LPN) and registered nurse (RN) scope of practice and development of a plan to ensure LPN-B was working within her scope of practice, ensuring one RN was responsible only for this one building, with the RN on site two to three times per week, and to follow-up on R5's bed rails. The Weekly Summary Report dated May 8, 2024, indicated the nurse consultant recommended a nurse follow-up on inappropriate bed rails (noting one of two resident bed rails were replaced), nursing follow-up on R2's record lack of face-to-face assessment and new order for bed rails. The report indicated the nursing team did not complete all of the action plan steps assigned by the nurse consultant. The report indicated the action plan for the facility to complete prior to consultant's next visit included the recommendation that one RN be responsible for this one building and that LPN-B follow-up on R2's bed rails pending face to face and orders. The Weekly Summary Report dated May 15,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27389	A. BUILDING: _____ B. WING _____	C 05/20/2024

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02310	Continued From page 10 2024, indicated the facility contracted with the consulting company to provide an interim Director of Nursing to be onsite full time. The report indicated the facility did not yet have R2's face to face assessment or bed rails orders. The report indicated the nursing team did not complete all of the action plan items assigned by the nurse consultant. The report recommended one RN be responsible for this one building and be onsite two to three days per week. The nurse consultant recommended re-evaluation of admission criteria, nursing needs, and staffing levels. The Side Rail policy dated December 27, 2023, indicated the licensee "only wants Halo Safety Ring side rails added to a bed when appropriate". The policy indicated a registered nurse must conduct an assessment of the side rails at a minimum of every 90 days to determine the intended purpose of the bed rail and the risks regarding the use of the bed rail. The policy indicated staff would determine if the side rail was "safe" and to be aware of "wobbly" side rails. The policy indicated the staff will determine if the bed rail is safe as defined by the following criteria: Ensure the bed rail was used consistent with manufacturer's directions, was installed securely, was maintained in good operating condition, and the bed rail was consistent with FDA's 2006 recommended dimensional measurements to reduce entrapment (zones 1, 2, and 3 must not exceed 4.75 [inches]). The policy directed staff to immediately report "wobbly" side rails to the nurse. The Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment document dated March 10, 2006, indicated evaluating the dimensional limits of the gaps in hospital beds	02310		

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02310	Continued From page 11 was one component of an overall assessment and mitigation strategy to reduce entrapment. The guidance document identified the hospital bed system used in the guidance consisted of the bed frame, mattress, bed rails, head, and foot boards. The guidance document indicated facilities should inspect, evaluate, maintain, and upgrade equipment (bed/mattress/bed rails) to identify and remove potential fall and entrapment hazards. The Halo Safety Ring Warnings document provided by the licensee, dated December 4, 2017, indicated the Halo Safety Ring required the following standards: " The mattress height must be between six and seven inches. " The mattress width must be 36, 37, or 38 inches. " Only high-quality mattresses should be used to ensure a proper weight to compressibility factor. " The mattresses used must be the proper length and width per the bed frame manufacturer's standards. A "WARNING" at the bottom of page 3 of the document indicated "the mattress must remain in firm contact with the Halo Safety Ring on both sides of the bed". Safety precautions listed on page 5 of the document indicated "regularly check to make sure that there is no gap between the Halo Safety Ring and the side of the mattress. A gap could allow entrapment. The FDA Recommendations for Health Care Providers Using Adult Portable Bed Rails website (https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails) retrieved	02310		

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02310	Continued From page 12 May 24, 2024, at 10:46 a.m. included the following information when using bed rails: " Inspect and regularly check the mattress and bed rails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and depth, the bed frame, bed rail, and mattress should leave no gap wide enough to entrap a patient's head or body. " Regularly assess that bed rails remain appropriately matched to the equipment and to the patient's needs, considering all relevant risk factors. " Inspect, evaluate, maintain, and upgrade equipment (beds, mattresses, and bed rails) to identify and remove potential fall and entrapment hazards. " Re-assess the person's needs and re-evaluate the equipment if an episode of entrapment or near-entrapment occurs, with or without serious injury. This should be done immediately because fatal "repeat" events can occur within minutes of the first episode. " Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed. No further information provided. TIME PERIOD FOR CORRECTION: TWO (2) 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	02360		

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02360	Continued From page 13 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 three of three residents reviewed (R1, R2, and R5) were 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	No plan of correction is required for this tag.	