Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304116824M
Compliance #: HL304112832C

Date Concluded: July 11, 2023

Name, Address, and County of Licensee Investigated:
Edgewood Brainerd Senior Living
14890 Beaver Dam Road
Brainerd, MN 56401
Crow Wing County

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

Evaluator's Name: Barbara Axness, 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 staff failed to reassess the resident after he returned to the facility following an emergency room visit. The resident became entrapped in a bedrail and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to reassess the resident and take proper safety measures to prevent harm when the resident returned from the emergency room (ER) after he was found entrapped in his bedrail. Approximately 11 hours later, the resident became entrapped in the bedrail a second time and died.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement, ambulance personnel, and the resident's physician. The investigation included review of emergency room

records, police reports, ambulance reports, the resident's death record, and facility medical records. At the time of the onsite visit, the investigator observed bedrails in use at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia without behavioral disturbance, type 1 diabetes, sleep walking, and obstructive sleep apnea. The resident's service plan included assistance with dressing, bathing, toileting, grooming, transferring, and medication administration. The resident's assessment indicated the resident was forgetful and moderately impaired, required cues and supervision, as well as reorientation. The resident also required assistance getting in and out of bed, and the bed was to be in the lowest position when the resident was in bed.

Facility incident reports indicated the resident fell out of his bed 11 times over the past three months. The reports identified the falls were a result of the resident having slipped or fallen out of bed. A progress note entered three days before the resident's death indicated, "All of his falls are related to his bed. Resident has a bariatric hospital bed, resident complained to his wife when he first got it that it was not comfortable, we suggested to wife that she purchase a memory foam topper, she then brought in an egg crate, resident continued to complain and she eventually swapped out the original mattress to bed with a normal twin bed mattress, which was causing a lot of falls due to it slipping off the frame so we asked for her to bring in an anti-slip material/dycem and she brought in Velcro, which we were able to make it work and we found some dycem to place between the mattress and frame to stop it from sliding off. But the full-size mattress compromises him being able to use bedrail and is too high causing him to roll out of bed…"

Hospital records identified the resident was evaluated in the ER around 2:00 a.m. the day he died. Facility staff found the resident "stuck between the bed and railing" and sent the resident to the hospital for an evaluation. The history and physical sections of the record indicated the resident reported he was "unable to get out of the position as he was stuck" and "he had a sensation of difficulty breathing when he was stuck in this position." The resident was treated for low blood pressure with intravenous fluids and for low blood sugar with food and juice, then discharged back to the facility.

Ambulance records from that same day indicated an emergency medical services (EMS) crew arrived at the facility shortly after midnight. The resident was found by staff with "his knees on the floor and his head stuck between the mattress and his railing of the bed. Staff state the patient's [resident's] face and arm were purple." The resident was transported to the ER and returned to the facility around 4:30 a.m. The ambulance was called back to the facility a second time that same day at 11:13 a.m. for a call of an unresponsive resident. The ambulance report indicated the resident was "located by staff trapped between the mattress and a safety rail. Staff were unable to free PT [resident] from this position. Law enforcement arrived on scene and was able to move PT [resident] to floor and start high quality CPR/airway management..."

According to the police report, officers arrived at the facility at 11:06 a.m. after receiving a complaint of an unconscious person who was not breathing and had no pulse. Three officers arrived and entered the resident's room where two unlicensed personnel (ULP) were found next to the resident, who was lying on the floor next to his bed. One ULP was sitting on the floor with the resident's head in her lap and told officers the resident was "wedged between the handrail and the mattress." Facility staff informed police the resident had a “Do Not Resuscitate” (DNR) order but did not have the paperwork in hand. Officers were unable to obtain a pulse but noted the resident was still "slightly warm to the touch, and Rigor Mortis [stiffening of the joints and muscles of a body a few hours after death] and Livor Mortis [bluish-purple discoloration of the skin after death] had not set in." Officers requested the resident’s DNR paperwork and moved the resident away from the edge of the bed. Officers initiated cardiopulmonary resuscitation (CPR) with the use of an automated external defibrillator (AED) to attempt lifesaving measures. Facility staff provided the resident’s DNR paperwork to police at 11:34 a.m., and lifesaving measures ceased. One of the officers contacted the Medical Examiner's Office to report the death and the resident's body was released to the funeral home.

Photos taken by responding police officers showed the resident’s room immediately after lifesaving measures were stopped and the resident was pronounced dead. A photo of the resident’s bed displayed bilateral bedrails, with the resident’s body laying alongside the bed. A large gap between the rail and the mattress was visible. A video recording reviewed included an officer’s description of how the resident was found while showing the bed. The resident was found partially on the bed, feet touching the ground, lying on his side, and wedged between the bed and bed railing.

During interviews, multiple unlicensed personnel (ULP) indicated it was well known among staff that the resident’s bed was the cause of most of his falls, and this concern had been reported to facility management. ULP indicated the resident’s bed was too high, they had trouble getting him in and out of bed, and he had a history of swinging his legs over the side of the bed. Several ULP said staff attempted to remove the bedrails after the resident became entrapped the first time but were unable to do so. Maintenance was not immediately called because the incident occurred during the overnight and early morning hours. One ULP recalled the resident was afraid to get back in bed after he returned from the emergency room.

Multiple nurses interviewed indicated the resident was using a donated hospital bed, and the original mattress it came with wasn’t comfortable to the resident. The nurses explained the resident’s wife eventually brought in a twin mattress, but it did not fit the bed frame well. The nurses confirmed the bed was the cause of most of his falls and were aware it was a problem. The nurses remembered contacting the resident's wife with requests to bring in various items to better secure the mattress but took no further measures to obtain a different bed or mattress. The nurses thought the resident’s wife had been informed of the risks related to the use of a bedrail and use of a mattress that didn’t fit the bed; however, no documentation was provided to confirm if or when the resident’s wife was informed of these risks.

During an interview, facility management indicated they were contacted after the resident was found entrapped in his bedrail the first time. Facility management then sent an email to the nurse scheduled to work the next morning, asking her to assess the resident and remove the bedrails from his bed. Facility management also sent this request in a message to the nurse via the facility's clinical documentation system, but the email and message were not received until after the resident died.

The resident’s wife was interviewed and did not recall the facility ever discussing risks associated with bedrail use.

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: No, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility immediately called 911 after discovery of the resident. A MAARC report was filed the same day. The facility completed a root cause analysis with an interdisciplinary team to identify issues and areas for improvement after the incident. All residents with bedrails were reassessed and the process for implementing bedrails was modified.

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
Crow Wing County Attorney
Brainerd City Attorney
Brainerd Police Department
Medical Examiner
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30411	A. BUILDING: _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BRAINERD SENIOR LIVING	14890 BEAVER DAM ROAD BRAINERD, MN 56401

(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****** HOME CARE PROVIDER/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: #HL304116824M/#HL304112832C On June 29, 2023, 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 99 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL304116824M/#HL304112832C, tag identification 2310, 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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 1 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 standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards for one of one residents (R1) with a hospital bedrail. 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: The licensee failed to reassess the resident and take proper safety measures to prevent harm after he returned from the emergency room and became entrapped in his bedrail. Approximately 11 hours later, the resident died after he became entrapped in his bedrail a second time. R1's diagnoses included dementia without behavioral disturbance, type 1 diabetes, sleep walking, and obstructive sleep apnea. R1's Service Plan dated June 8, 2023, indicated R1 required assistance with dressing, bathing, toileting, grooming, transferring, and medication administration. R1's most recent assessment dated June 8,	02310		

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02310	Continued From page 2 2023, indicated the resident was forgetful and moderately impaired, requiring cues and supervision, as well as reorientation. R1 was noted as needed assistance getting into and out of bed, the bed was to be in the lowest position when resident was in bed, and staff "have requested wife get him a new mattress." R1's bed safety assessment, last updated June 8, 2023, indicated the resident used an electric bed/hospital bed with a memory foam mattress. Mattress not original to bed, has non-slip material and Velcro placed in between mattress and metal hospital bed frame to aid from mattress sliding. Anti-slip material placed in the center of the bed between mattress and metal hospital (sic) to further aid with mattress from slipping." R1 was able to use side rail for transfers and positioning and bed rail will not be used as a restraint. Bed rail has been installed on bed and will be maintained according to manufacturer guidelines. Manufacturer guidelines available upon request. The bed rail was noted to not meet FDA guidelines but "wife aware; risks vs benefits of bed rails." R1's progress notes included the following entries: -On March 16, 2023, the resident fell while trying to get up to use the bathroom. It was noted, "mattress slide backwards and he slide out and landed on his right side and hit his head on the bed frame on the way down. Resident has hospital bed, but family purchased a new mattress to aid in comfort. Residents wife will bring in non slip material to place in between mattress and metal hospital bed frame to aid from mattress sliding." -On April 2, 2023, the resident was found sitting on the carpeted floor with his back against his	02310		

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02310	Continued From page 3 bed, bedding wrapped around him. The resident was noted to have sat on the edge of the bed and slid down. -On April 15, 2023, the resident slid out of bed and was found sitting on the floor. -On April 17, 2023, the resident had a fall and "once again found seated on carpeted ground next to bed with back resting against the frame." -On May 11, 2023, the resident had a fall out of bed and bumped the back of his head. -On May 19, 2023, the resident slid out of bed onto the floor and landed on his buttocks. -On May 23, 2023, the resident slipped out of bed and hit his head on his bed railing. The nurse practitioner was notified of his two recent falls. -On May 28, 2023, the resident was found laying on the carpeted floor next to his bed laying on his back. R1 reported he had slipped out of bed. -On May 30, 2023, the resident's nurse practitioner was notified about the resident's recent falls, with staff "Wondering if we could get an order for PT to work with him for safe transfers in and out of bed, I know resident was discharged last time due to being non compliant but due to recent falls feels like he might be more willing to do this time around." -On June 3, 2023, the resident fell out of bed. -On June 7, 2023, the resident fell around 7:00 a.m. and was found on the right side next to his bed. The note indicated he was sleeping and slipped out of bed. -On June 8, 2023, the resident's wife was contacted to bring in a new mattress. Staff documented, "All of his falls are related to his bed. Resident has a bariatric hospital bed, resident complained to his wife when he first got it that it was not comfortable, we suggested to wife that she purchase a memory foam topper, she then brought in an egg crate, resident continued to complain and she eventually swapped out the	02310		

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02310	Continued From page 4 original mattress to bed with a normal twin bed mattress, which was causing a lot of falls due to it slipping off the frame so we asked for her to bring in an anti slip material/dycem and she brought in Velcro, which we were able to make it work and we found some dycem to place between the mattress and frame to stop it from sliding off. But the full size mattress compromises him being able to use bedrail and is too high causing him to roll out of bed. Wife does not seem to listen to us, wondering if she would be more compliant if you informed her he needs to have the normal mattress to bed with a 1-2 inch memory foam topper." -On June 11, 2023, the on call nurse was notified at 12:33 a.m., after the resident fell from bed and his head was between the bed and the rail. 911 was called and the resident was sent to the ER for evaluation. The resident returned to the facility at 5:00 a.m., talked to his wife around 9:00 a.m., laid down around 9:45 a.m., and had his blood sugar checked by the nurse at 10:00 a.m. At 11:00 a.m., staff found the resident "partially out of bed with his head between the bed and the rail with his chin resting on the rail. They were able to get him to the floor while 911 was being called..." CPR was attempted until a do not resuscitate order was located. The resident was declared dead at 11:34 a.m. Emergency room records indicated the resident arrived to the ER around 2:10 a.m. on June 11, 2023, after the resident had rolled off his bed and "got stuck between the bed and the railing." The history and physical sections included that the resident reported he was "unable to get out of the position as he was stuck" and stated "he had a sensation of difficulty breathing when he was stuck in this position." Staff found the resident a few minutes later and helped him get out of the	02310		

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02310	Continued From page 5 bedrail. The resident was treated for low blood pressure with intravenous fluids and for low blood sugar with food and juice and was discharged back to the facility. Ambulance records indicate an ambulance was called to the facility at 12:35 a.m. on June 11, 2023, after staff found the resident with "his knees on the floor and his head stuck between the mattress and his railing of the bed. Staff state the patient's [resident's] face and arm were purple." The ambulance report indicated the resident had a history of sleepwalking. Due to low blood pressure and complaints of pain, the resident was taken to the ER. The ambulance brought the resident back to the facility at 4:31 a.m. on June 11, 2023. The ambulance was called again on June 11, 2023, at 11:05 a.m., and emergency crews arrived at 11:13 a.m. after the resident was found unresponsive. The ambulance report indicated law enforcement was already performing CPR upon their arrival. The report indicated the resident was "located by staff trapped between the mattress and a safety rail. Staff were unable to free PT [resident] from this position. Law enforcement arrived on scene and was able to move PT [resident] to floor and start high quality CPR/airway management..." Facility were initially unable to locate the residents DNR order so CPR continued until the order could be located. Facility staff brought the DNR order at 11:34 a.m., at which time CPR was stopped and the time of death was called. The ambulance crew then left the scene as law enforcement assumed control of the scene. The police report indicated they arrived at the facility at 11:06 a.m. on June 11, 2023 after a report of an unconscious person not breathing with no pulse. Three officers arrived and entered	02310		

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02310	Continued From page 6 the resident's room where two unlicensed personnel were next to the resident, who was lying on the floor next to his bed. One ULP was sitting on the floor with the resident's head in her lap and told officers the resident had been "wedged between the handrail and the mattress."Facility staff informed the police officers the resident had a DNR but did not have the paperwork in hand. The officers were not able to feel a pulse but noted the resident was still "slightly warn to the touch, and Rigor Mortis and Livor Mortis had not set in." Officers requested the paperwork and moved the resident away from the edge of the bed and began lifesaving measures, including CPR and use of an AED. Facility staff brought the DNR order at 11:34 a.m., and lifesaving measures were stopped. One of the officers contacted the Ramsey County Medical Examiner's Office to report the death and the resident's body was released to the funeral home. Photos taken by responding police officers showed the resident's room immediately after lifesaving measures were stopped and the resident was pronounced dead. A photo of the resident's bed showed bilateral bedrails with the resident's body laying alongside the bed. A large gap between the rail and the mattress was visible. A video recording included an officer describing how the resident was found while showing the bed. The resident was described as found on the bed partially, feet touching the ground, laying on his side and wedged between the bed and bed railing. Documentation of reviewing risks of bedrail use with R1's wife or responsible party was requested, but not provided.	02310		

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02310	Continued From page 7 On June 28, 2023, at 12:15 p.m., R1's wife stated someone had donated a hospital bed that R1 was using and she got him a new mattress for it but he kept swinging his legs towards the bottom. R1's wife stated she spoke with him a few hours before he passed away and seemed wonderful and they were both laughing. R1's wife stated it was a complete shock when the sheriff called her to let her know he had passed away. R1's wife stated she did not recall the facility ever talking about the risks of using a bedrail with her. On June 29, 2023, at 2:55 p.m., clinical nurse supervisor (CNS)-A confirmed R1 was not reassessed for appropriate bedrail use after he went to the emergency room. CNS-A stated staff had tried to remove the bedrails after the resident left for the ER but maintenance was not called for assistance as it was still the middle of the night. CNS-A stated she sent an email to the nurse working the next morning asking her to reassess the resident and remove the bedrails from his bed and that an RTasks (computer documentation system) message was sent to notify staff of the ER visit. CNS-A stated the nurse working the morning he died, RN-F, did not see the email until after the resident had passed away. CNS-A stated the resident had a bariatric bedframe with a twin sized mattress on it and they had identified the bedrail as being a possible issue. CNS-A stated staff had kept trying to reach out to the resident's wife but they weren't aware she wasn't returning calls as she was in the hospital and later a nursing home following a procedure. CNS-A stated the bedrail in use did meet FDA guidelines. On June 29, 2023, at 12:50 p.m., registered nurse (RN)-H stated the resident would primarily have falls from his bed because he'd get too	02310		

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02310	Continued From page 8 close to the edge of his bed and slip right off the edge. RN-H stated they had been working with the resident's wife to try get a different mattress in because it did not fit well on the bed frame. RN-H stated the bed had been donated and thought the bedrails were on it at the time it was donated and brought to the resident's room. RN-H stated she thought staff had reviewed the risks of using a bedrail with the resident's wife and they would normally provide a handout and other information on bedrails. RN-H was not sure when the resident's wife would have been notified of the risks but thought it would have been around the time he started using the donated bed. On June 29, 2023, at 1:10 p.m., RN-I stated when the resident first admitted to the facility, he only had a mattress on the floor and it was difficult for the resident to get in and out of bed. RN-I stated she knew of a donated bed frame so had suggested the resident use that so he'd at least have an actual bed. RN-I stated the mattress that came on the bed frame was uncomfortable to the resident and they requested his wife bring in a mattress topper but one day, she brought in a full sized mattress. RN-I stated the bed frame was a bariatric one so the twin sized mattress was too small for the frame and the resident had an increase in falls because he'd slide off the bed. RN-I stated they had reached out to his wife again to see if she could bring in some non-skid material like dycem and she brought in Velcro to help secure the mattress. RN-I stated the mattress was a contributing factor in some of his falls and they asked his wife to take it home and bring a different mattress and they tried to tell her it wasn't going to work but due to finances or something, she wasn't able to get a different mattress.	02310		

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	30411	A. BUILDING: _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 9 On June 29, 2023, at 1:45 p.m., unlicensed personnel (ULP)- D stated she came over to R1's room after someone had said over the walkie they needed assistance. ULP-D stated when she came to R1's room, he was on the ground and they were trying to roll him over. ULP-D stated the resident was a bit cool to the touch and blue in the face. On July 3, 2023, at 9:10 a.m., RN-F stated she was working on the medication cart from 6:00 a.m. to 10:00 a.m. on June 11, 2023 and normally worked on the assisted living side, not the memory care side where R1 lived. RN-F stated she had checked the resident's blood sugar a little after 10:00 a.m. and the resident was sleeping comfortably at that time. RN-F stated she didn't recall if there was a gap between the mattress and the bedrail. RN-F stated she knew the resident had been in the emergency room earlier that day but since she can get a lot of RTasks (computer documentation system) messages, she couldn't recall what the message said. RN-F confirmed she hadn't received any guidance to remove the bedrail since she had not checked her email. On July 3, 2023, at 9:55 a.m., ULP-B stated she was the one who found R1 around 11:00 a.m. on June 11, 2023. ULP-B stated at the start of her shift, they were notified that R1 had fallen out of his bed earlier and was wedged between his bedrail and the bed and ended up going to the ER. ULP-B stated she made sure to check on R1 right after starting her shift because his feet would fall out of bed a lot and "I went in there to make sure his feet were in bed and that he was in bed because his bed is pretty high and it's not a good drop to fall out of." ULP-B stated she went on break a little after 10:00 a.m., and checked on all	02310		

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02310	Continued From page 10 her residents before leaving for break and R1 was still sleeping in his bed. ULP-B stated when she came back around 10:45 a.m., she would normally again go check on her residents but she got pulled to go help someone else first. ULP-B stated when she walked by R1's room, she noticed his feet were not in the bed. ULP-B stated he was partially on the bed, partially out and she screamed for help since she wasn't able to move him by herself and some other staff came in and she went to call 911. ULP-B stated everybody had mentioned to nursing that R1's bed was too high and they were just told they were looking into it or would get maintenance to take care of it. ULP-B stated the staff working the overnight shift when R1 was sent to the ER tried to remove the bedrail but they were unable to do so and she and another staff member also tried to remove the bedrail as the resident was afraid to get back in his bed but they couldn't get it off. The licensee's Side Rail policy, updated October 2022, indicated when Edgewood is aware a resident is utilizing side rails (a medical device) on a bed, Edgewood will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify the side rails in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "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,	02310		

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02310	Continued From page 11 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 to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated June 20, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements."	02310		

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02310	Continued From page 12 Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. 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: Based on interview and record review, the facility failed to ensure one of one of one resident (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	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	