DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333107565M
Compliance #: HL333104183C

Date Concluded: August 29, 2023

Name, Address, and County of Licensee Investigated:
Meadows of Wadena
110 Hemlock Ave NW
Wadena, MN 56482
Wadena 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 a resident when staff failed to assess the resident's ability to use bedrails after she experienced a change in condition. 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's ability to safely use bedrails after a decline in condition. The resident became entrapped in the bedrail and died.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted hospice, law enforcement, and the funeral home. The investigation included review of the resident's medical records including assessments, bedrail assessments, the service plan, progress notes, hospice

records, and the sheriff's office report. Also, the investigator observed bed rails in use at the facility.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included Alzheimer's dementia and anxiety. The resident's service plan included assistance with dressing, grooming, bathing, bed mobility, safety checks, behavior management, and medication management. The resident's assessment indicated the resident was nonverbal and dependent on staff to complete activities of daily living.

A Bedrail Use Assessment form completed approximately four months before the resident's death, indicated the bedrail was used to assist with turning from side to side and holding self to one side. The bedrail was noted to help the resident exit, enter, and transfer into the bed more safely, assist with rolling out of bed, and provided a sense of security. Measurements taken indicated the bedrail was within the dimensions as identified by FDA guidelines. A box was checked "yes" indicating the FDA bedrail brochure was provided and that the registered nurse (RN) had explained the risk/burden/benefit of bedrails. The form did not indicate who was educated on risks or who was given the FDA brochure.

The resident's most recent assessment, completed approximately two months before her death, indicated the resident required two-person physical assistance to get in and out of bed, due to needing verbal and physical cueing. The resident was nearly nonverbal and needed assistance for all mobility. The resident utilized a low bed with a mattress that was original to the bed. A partial side rail (bedrail) was in use to assist the resident with getting in/out of bed. The resident was noted to be at high risk for injury if a side rail was in use due to her cognition/Alzheimer's dementia. Side rails were determined to be appropriate based on the assessed need. A section indicating if education was provided to the resident/responsible party of the risks and benefits of the bed rails with verbalized understanding was marked "yes".

The resident's progress notes over the past six months were reviewed. The progress notes contained only five entries during this time, with the most recent entry from almost three months prior to the resident's death.

Hospice records indicated about ten days before the resident died, facility staff reported it was harder to transfer the resident due to increased stiffness. A progress note from three days prior to the resident's death, indicated the resident had decreased strength in her lower and upper bilateral extremities and required max assistance for transfers to the bed or chair. The progress note indicated the resident was in bed all the time now and meal intake had decreased. The resident was noted to not be able to hold herself upright in a chair anymore.

The report from the Sheriff's Office indicated dispatch was called an hour after the resident was found dead, and the responding deputy arrived a few minutes after the call was made. Facility staff had moved the resident's body from the position she was found in and placed her lying prone on the bed. Body camera footage included the licensed assisted living director (LALD)

telling the responding deputy they moved the resident “for the family’s sake and for staff’s sake.” The resident’s body was described as found with her body on the ground and her chin stuck underneath the bedrail. Photographs taken by the responding deputy showed a dark purple bruise from her ear down past her chin. Other photographs showed the resident lying prone on the bed with the bedrail in place. The bedrail appeared consistent with the description in the resident’s most recent assessment. The LALD stated the resident had become bedbound within the last week and was not able to use her feet/legs. The responding deputy noted livor mortis had set in (pooling of blood and discoloration that occurs around 30 minutes after death), but rigor mortis (stiffened muscles occurring two to four hours after death) had not.

During an interview, the LALD stated "We don't normally do progress notes...it's not like long term care where we do them daily" The LALD stated she was called a few minutes after the resident was found in the bedrail and she arrived about a half hour later. The LALD stated the resident was on the floor by her bed and had a bruise under her jaw on the side that was stuck in the bedrail, with some pooling of blood noted on the other side of her neck. The LALD stated she wasn't sure how the incident happened as the resident was "mostly dead weight" on the lower half of her body. The LALD indicated she felt the resident was still appropriate to use bedrails, even though she couldn’t use them independently and staff would put her hands on them to help with turning and repositioning while she was in bed.

A facility RN stated "We've never done a lot of progress notes, it's never been a requirement, so we've never done a lot." The RN stated the resident had slowly declined over the last few months and needed more assistance with transfers. The RN noted the resident was more bed bound, had difficulty sitting up in her wheelchair, and difficulty being able to sit upright. The RN couldn't recall when the resident’s Power of Attorney (POA) was informed of the risks related to bedrail use but stated it would have been covered when the resident began using the siderails. The RN stated the risks were only reviewed that one time, but she reassessed the appropriateness of the bedrails with each assessment. The RN felt the resident was appropriate to use the bedrails as she was able to grab on to them if staff placed her hands on it to help with repositioning in bed, but confirmed she was not able to use them independently and did not use them for transfers in and out of bed.

Unlicensed personnel (ULP) who worked the night the resident died, stated she was found with the lower half of her body off the bed and on the floor, and her head trapped in the lower part of the bedrail. ULP stated it took two people to get her “unstuck” from the bedrail. One ULP stated she had no idea how the incident happened as "we literally have to pick her legs up; it takes two of us to turn her." Several ULP stated the resident couldn’t use the bedrails to get in and out of bed but was sometimes able to hold on to them for positioning in bed if directed to do so by staff. The ULP also indicated the resident declined over the last month, was more bed bound, and did not get out of bed as often as she used to. ULP stated the resident had a history of putting her legs over the side of the bed and staff would have to pick them up and put them back in the bed.

The hospice nurse stated the resident's condition had declined over the last few weeks of her life. The hospice nurse recalled the resident's head seemed to always be down and she wasn't lifting her head up. The hospice nurse stated the resident would not have been able to safely use the bedrails over the last few months due to her decline. The hospice nurse indicated the resident did not have the cognitive ability to use them [bedrails] and they wouldn't have been helpful for positioning or bed mobility as she required physical assistance from staff for bed mobility. The hospice nurse stated when the resident first admitted to hospice, she would have been appropriate for bedrails as she was ambulatory, but after she started requiring physical assistance for transfers and mobility, she would not have been able to use them safely. The hospice nurse stated the facility did not bring forward any concerns on bedrail safety and she "would rely heavily on their input on that because they're there with the person so much more than we are."

The resident's husband stated he was not aware the resident had been found entrapped in the bedrail until informed by the investigator. The resident's husband did not recall the facility ever talking to him about the risks related to bedrail use and stated he was given a lot of papers to sign but did not read everything.

A preliminary autopsy report indicated the resident's cause of death was probable asphyxia.

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:
No action taken.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Wadena County Attorney
Wadena City Attorney
Wadena Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing
Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33310	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF WADENA	110 HEMLOCK AVENUE NW WADENA, MN 56482

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0 000	Initial Comments ******REVISED****** Upon reconsideration, changes have been made. ******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: #HL333107565M/ #HL333104183C On August 8, 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 43 residents receiving services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on August 11, 2023, for #HL333107565M/ #HL333104183C tag identification 2310. On August 17, 2023, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 4, scope of pattern violation.	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.	

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0 000	Continued From page 1 The following correction order are issued for #HL333107565M/ #HL333104183C tag identification 2310 and 2360.	0 000		
02310 SS=J	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 standards. This MN Requirement is not met as evidenced by: Based on observation, 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 two of two residents (R1, R2) with a hospital bedrail. R1 died after becoming entrapped in the bedrail. R2 was not reassessed after she experienced a change in condition and was no longer able to use bedrails appropriately. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). The findings include: This resulted in an immediate correction order on August 11, 2023, at approximately 3:00 p.m.	02310		

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02310	Continued From page 2 R1 The licensee failed to reassess the resident's ability to safely use bedrails after her health status declined and was no longer able to use bedrails appropriately. R1 died after she became entrapped in the bedrail. R1's diagnoses included Alzheimer's dementia and anxiety. R1's Service Plan dated April 25, 2023, indicated the resident received services including behavior management, reminders for meals, assistance with toileting, bathing and dressing, medication administration, eight times per day safety check, and assistance with bed mobility. A Bedrail Use Assessment form completed on March 9, 2023, indicated the bedrail would be used to assist with turning from side to side and holding herself to one side. The bedrail was noted to help the resident exit, enter, and transfer into the bed more safely and also assist with rolling out of bed and providing a sense of security. Measurements taken indicated the bedrail was within the dimensions as identified by FDA guidelines. A box was checked "yes" indicating the FDA bedrail brochure was provided and that the RN had explained the risk/burden/benefit of bedrails. R1's most recent assessment dated May 18, 2023, indicated the resident needed two person physical assistance to get in and out of bed due to needing verbal and physical cueing. The resident was noted to be nearly nonverbal and needed staff assistance for all mobility. The resident's bed was a low bed with a mattress that	02310		

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02310	Continued From page 3	02310		

was original to the bed. A partial side rail was in use to assist the resident with getting in/out of bed. The resident was noted to be at high risk for injury if a side rail was in use due to her cognition/Alzheimer's dementia. The assessment indicated the side rails were determined to be appropriate based on R1's assessed need. A section of the assessment identifiying if education had been provided to the resident/responsible party of the risks and benefits of the bed rails and understanding was verbalized, was marked "yes."

Progress notes from January 1, 2023, through July 30, 2023, were requested. R1's progress notes contained only five entries throughout this time period. The most recent note was entered on May 8, 2023, after a fall.

R1's service recap summary for July 2023, indicated the resident was asleep during the midnight, 1:00 a.m., 2:00 a.m., and 3:00 a.m. safety checks.

Hospice records from July 20, 2023, indicated facility staff reported it was harder to transfer R1 due to increased stiffness.

A progress note from July 27, 2023, indicated the resident had decreased strength in her lower and upper bilateral extremities and required max assistance for transfers to the bed or chair. The progress note indicated the resident was in bed all the time now and meal intake had decreased. The resident was noted to not be able to hold herself upright in a chair anymore.

A report from the Sheriff's Office indicated dispatch was called at 5:17 a.m. on July 30,

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02310	Continued From page 4 2023, and the responding deputy arrived at 5:21 a.m. The responding deputy noted livor mortis (pooling of blood and discoloration that occurs around 30 minutes after death) had set in but rigor mortis (stiffened muscles occurring two to four hours after death) had not. Facility staff had moved the resident's body from the position she was found in and placed her lying prone on the bed. Body camera footage included the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A telling the responding deputy they moved the resident "for the family's sake and for staff's sake." The resident's body was described as found with her body on the ground and her chin stuck underneath the bedrail. Photographs taken by the responding deputy showed a dark purple bruise from her ear down past her chin. Other photographs showed the resident lying prone on the bed with the bedrail in place. The bedrail appeared consistent with the description in the resident's most recent assessment. LALD/CNS-A stated the resident had become bedbound within the last week and not able to use her feet/legs. On August 8, 2023, at 11:50 a.m., LALD/CNS-A stated "We don't normally do progress notes...it's not like long term care where we do them daily" LALD/CNS-A stated she was called at 4:02 a.m. on July 30, 2023, after R1 was found in the bedrails. LALD/CNS-A stated she arrived at the facility around 4:38 a.m. and R1 was on the floor by her bed. LALD/CNS-A stated the resident had a bruise under her jaw on the side that was stuck in the bedrail and some pooling of blood noted on the other side of her neck. LALD/CNS-A stated she wasn't sure how the incident happened as the resident was "mostly dead weight" on the lower half of her body.	02310		

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02310	Continued From page 5 On August 8, 2023, at 12:10 p.m., registered nurse (RN)-B stated "We've never done a lot of progress notes, it's never been a requirement so we've never done a lot." RN-B stated R1 had been slowly declining over the last few months and needed more assistance with transfers. RN-B stated R1 was becoming more bed bound and had difficulty sitting up in her wheelchair and sitting upright. RN-B couldn't recall when R1's power of attorney was informed of the risks related to bedrail use but stated it would have been covered when the resident began using the rails. RN-B stated the risks were only reviewed one time but she would reassess the appropriateness of the bedrails with each assessment. RN-B stated R1 was appropriate to use the bedrails as she was able to grab on to them to help with repositioning in bed. On August 9, 2023, at 9:25 a.m., unlicensed personnel (ULP)-C stated she was working the night R1 died and she was called over to help when she was found entrapped in the bedrails. ULP-C stated R1's lower half was off the bed and on the floor and R1's head was trapped in the lower part of the bedrail. ULP-C stated she had to lift R1's head up to try get it out of the bedrail and she and another staff member were able to free the resident and lay her down on the floor. ULP-C stated she had no idea how the incident happened as "we literally have to pick her legs up, it takes two of us to turn her." ULP-C stated R1 wasn't able to use the bedrails to get in and out of bed but was able to hold on to them for positioning in bed. On August 9, 2023, at 9:35 a.m., ULP-D stated she was working in the memory care unit the	02310		

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02310	Continued From page 6	02310		

night R1 died and she had been doing hourly checks on the resident. ULP-D stated she'd always go in and make sure the resident was breathing and safe in bed, and R1 was "fine" at the 3:00 a.m. check. ULP-D stated she and another staff member went into R1's room at 4:00 a.m. to change her incontinence product and when they rounded the corner, they saw she was "laying off the bed, her legs were off the bed and her neck was down by the rails." ULP-D stated they looked to see if she was breathing and realized she wasn't. ULP-D stated she lifted the resident's legs a bit to get the weight off her neck and the other staff member had to twist a bit to get the resident unstuck from the bedrail. ULP-D stated R1 was able to get her legs off the side of the bed on occasion and they'd have to pick her legs up and put her back into bed. ULP-D stated the resident had become more bed bound lately and had not been getting up as much as she used to. ULP-D stated the resident wouldn't use the bedrails to get in and out of bed but she would use the rails to try pull herself up or "we'd ask her to help us turn on her side and she'd grab the railing to try help."

On August 10, 2023, at 11:45 a.m., R1's power of attorney (POA)-E stated he did not recall anyone at the facility talking to him about the risks associated with bedrail use. POA-E stated he had received a bunch of paperwork to sign when she moved in that he was supposed to read and sign but "I can't say I read them all." POA-E stated he had not been told by the facility the resident was found entrapped in the bedrail and was not aware this happened until informed by the MDH investigator. POA-E stated when he arrived about an hour after she was found dead, she was laying on her back in the bed.

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02310	Continued From page 7 On August 11, 2023, at 10:00 a.m., hospice nurse (HN)-G stated over the last few weeks of R1's life, she had started to decline and her head seemed to always be down a lot and wasn't lifting her head up. HN-G stated R1 wouldn't have been able to safely use the bedrails the last few months, due to her decline, as she wasn't cognitively able to use them and they wouldn't have been helpful for positioning or bed mobility, since she required physical assistance from staff for bed mobility. HN-G stated when the resident first admitted to hospice, she would have been appropriate for bedrails as she was ambulatory but after she started requiring physical assistance for transfers and mobility, she wouldn't have been able to use them safely. HN-G stated the facility did not bring forward any concerns on bedrail safety and she "would rely heavily on their input on that because they're with the person so much more than we are." On August 11, 2023, at 1:10 p.m., RN-B confirmed R1's health status began to decline around May or June of 2023 and went from walking with minimal supervision, to requiring extensive assistance of one to two staff members for mobility. RN-B stated towards the last month of the resident's life she had difficulty holding her head and torso up. RN-B confirmed R1 was not able to independently grab on to the bedrails and required staff to place her hand on the bedrails. Once staff had placed her hand on the bedrails, R1 would be able to grip the bedrail. RN-B stated despite R1's decline and inability to independently use the bedrails, nursing staff felt she was still appropriate to use them, as this would assist staff if they needed to turn her to change her incontinence product.	02310		

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02310	Continued From page 8 On August 11, 2023, at 3:15 p.m., LALD/CNS-A stated she felt R1's bedrail use remained appropriate even though staff would have to place her hand on the bedrail for her to assist with turning in bed. A preliminary autopsy report indicated the resident's cause of death was probable asphyxia. R2 The licensee failed to reassess the resident's ability to safely use bedrails after she began to decline and was no longer able to use bedrails appropriately. R2's diagnoses included dementia, type two diabetes, and anxiety. R2's service plan, last updated July 19, 2022, indicated the resident received services including reminders for meals, assistance with toileting, bathing and dressing, medication administration, three times per day safety checks, and behavior management. R2's most recent assessment, dated May 12, 2023, indicated R2 had been bedbound since April 28, 2023, and needed assistance with turning and repositioning, as well as having her incontinence product checked every two hours and as needed. R2 also received hospice services. R2 was not able to activate the emergency call system due to impaired cognition. R2's assessment included a bedrail assessment which indicated the bedrails were used to assist R2 with getting in and out of bed. R2 was noted to be at high risk for injury if bedrails were in use but the assessment	02310		

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	33310	A. BUILDING: _____ B. WING _____	C 08/08/2023

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02310	Continued From page 9 indicated the bedrails were determined to be appropriate based on need. R2's progress notes from January 1, 2023, through August 11, 2023, were requested. The most recent progress note entry was dated May 22, 2023. On August 8, 2023, at 9:50 a.m., R2 was observed laying in bed with the bed low to the ground and bilateral bedrails in place. On August 11, 2023, at 2:45 p.m., RN-B stated R2 required one to two people for assistance with transfers on her "good days" when R2 was more awake. RN-B stated on days R2 was more lethargic and couldn't sit up or help bear weight, R2 spent most of her time in bed. RN-B stated R2 used her bedrails mostly for support, as staff turned and repositioned her and had her turn from side to side. RN-B stated R2 would have "bad days" where she didn't get out of bed as she didn't have as much strength; however, RN-B felt R2's bedrails were still appropriate on R2's "good and bad days." On August 11, 2023, at 3:15 p.m., LALD/CNS-A stated R2 used her bedrails for repositioning. LALD/CNS-A indicated R2 did not transfer in and out of bed on her own, so the bedrails were not used for that purpose. LALD/CNS-A stated R2 would have good and bad days where she was able to transfer out of bed with one or two staff assist and there were other days where R2 couldn't stand on her own. LALD/CNS-A stated R2 would sometimes hold on to the bedrails when staff were changing incontinence products or turning her.	02310		

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02310	Continued From page 10 The licensee's Assessing the Safety of Side Rails policy, dated September 2017, indicated the RN would provide for any resident who has a side rail or is considering obtaining one, education regarding side rail safety and risks including potential death due to falls, entrapment, and asphyxiation. The RN would provide information on side rails/bedrails to the resident or resident's responsible party. 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, 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	02310		

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02310	Continued From page 11 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." 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: IMMEDIATE	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.	02360		

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02360	Continued From page 12 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents 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	No plan of correction is required for this tag.	