Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336513421M
Compliance #: HL336513620C

Date Concluded: July 15 ,2024

Name, Address, and County of Licensee Investigated:
Springbrook Village La Crescent
1384 County Rd 25
La Crescent, MN 55947
Houston County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the facility allowed a siderail to be used which the resident became entrapped in and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility did not have a system in place to ensure the resident's side rail was placed properly nor to ensure it was maintained in that condition. After returning from a hospital stay with changes to the resident's medication regimen, the resident was found dead with her head and neck lodged between the siderail and her bed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement, the medical examiner's office, emergency response services, and a family member. The investigation included a review of the resident's facility bedrail policy, progress notes, death

record, autopsy report, coroner photos, call pendant log, staff schedule, resident service plan, and recent hospital record. Also, the investigator made an onsite visit and observed bedrails in use at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included osteoarthritis (degenerative joint disease), congestive heart failure (heart cannot pump blood well enough), and polyneuropathy (damage to multiple nerves). The resident's service plan included assistance with medication administration, compression stockings, and monitoring of vital signs. The resident's assessment indicated she used a four-wheel walker and was independent with transfers and getting in and out of bed.

The facility incident report indicated one morning an unlicensed caregiver entered the resident's apartment and found the resident with her head and neck stuck between the mattress and the siderail. The resident was described as unresponsive. The same document indicated 911 was called and the unlicensed caregiver raised the resident's head out form the siderail and mattress.

Approximately three months prior to the resident's death the facility completed a siderail assessment which indicated the resident had a history of falls and difficulty with bed mobility and going from a lying to position to a sitting position in bed. The assessment indicated the resident used a siderail for positioning and support. The same assessment indicated positive and negative aspects of siderail use had bene discussed with the resident although the document did not indicate what the specific risks were to the resident. The same form listed under recommendations bilateral side rails.

The resident's monthly electronic medication administration (EMAR) indicated the facility administered furosemide (a diuretic) 20 milligrams (mg) twice day for water retention. The resident received this medication up until a hospitalization that occurred about 10 days prior to her death.

Ten days prior to her death, the resident was hospitalized due to shortness of breath, peripheral edema (leg swelling caused by excess fluid in the tissues), weight gain, and decreased activity tolerance. The resident was in the hospital for about four days and then returned to the facility with an increase in her diuretic medication on the fifth day.

The facility did an assessment upon return from the hospital and made note of the recent hospitalization. This assessment indicated resident used half bed rails as a supporting resource for getting in and out of bed. The same assessment indicated the resident was at moderate risk for falls. The assessment did not indicate the increase of the resident's diuretic or additional need for monitoring.

For the five days prior to the resident's death the EMAR indicated the facility administered the increased dose of furosemide 40 mg twice a day.

Three days prior to the resident's death the facility completed a monthly check which included a set of vital signs which indicated a blood pressure of 104/70 and a pulse of 62. The same document indicated the resident had pain in her feet, legs, and knees but included no other information. A review of the resident's medical record identified no other follow-up to these findings.

The resident's progress notes on the morning of she died indicated the cause of her death was "not sure" while also indicating she was found with her head stuck in her siderail.

The resident's autopsy indicated she had multiple contusions along the neck and the left neck furrow while noting the resident was found with her neck "compressed" between a siderail and a bed. The same document included a description of "blunt force" injuries to the resident's neck and torso. According to this document, the resident died as a result of positional asphyxia.

The resident's death record listed the immediate cause of death as positional asphyxia [suffocation].

During an interview, an unlicensed caregiver stated the morning of the incident she entered the resident's apartment, went to collect the diabetic supplies in the resident's bathroom and when she walked into the bedroom the resident was not on the bed but could see her head was on the mattress. The unlicensed caregiver then walked around the bed and found the resident's body off the bed and her head and neck caught between the siderail and mattress. The unlicensed caregiver stated she felt the resident's face which felt cold to touch and tapped her cheek and said her name with no response. The unlicensed caregiver stated the resident was facing towards the window with her head slightly turned and body twisted but with her head trapped. The unlicensed caregiver stated she lifted and released the resident's head from the rail and then called 911. She said the siderail was located on the right-hand side of the bed which is the side the resident uses to get in and out of bed.

During an interview, a manager stated the siderails are not managed or maintained by maintenance. The manager stated when residents move in the facility hires a moving company to help and could not say who put the siderail on the resident's bed at the time of the move. The manager stated he was not personally familiar with the actual siderail in the resident's room.

During an interview, a nurse stated the resident had her own single bed and could not state who installed the siderail. The siderail was located on the right side of the bed only and was used by resident for bed mobility and to assist resident to a sitting position. The nurse stated there was not any orders for the siderails. The nurse stated the facility assessed siderails quarterly and looked at guidelines of the Food and Drug Association but not at the manufacturer's recommendations. While discussing the assessments, the nurse stated they did not indicate if the siderails were in working order. The nurse stated the facility did not have the manufacturer's instructions which was not consistent with the facility's written policy. She

stated if the resident or resident's family member or representative requested siderails the facility verbally goes through the risks and benefits with them.

During an interview with a family stated the bed was a twin-size bed with frame, box spring, and mattress and had two handrails on it. She stated there were two siderails on the bed and the resident owned the one on the right side, but she was not sure how the one on the left side came to be in place. The resident also used a step stool on the right side of the bed where the resident got in and out of bed which was used because the resident was short and needed a stool to get in and out of the bed.

An image provided by the medical examiner office showed the resident deceased on the floor on the right side of the bed (from the head of the bed perspective) with the siderail on the same side of the bed visible. The image also shows another siderail near the foot of the bed on the left side of the bed.

A review of the resident's medical record showed no reference to the siderail at the foot of the bed on the left side.

The investigation included a request for the facility to provide a copy of the manufacturer's directions and any documentation of the facility's maintenance records of the siderail(s) located on the resident's bed. The facility did not provide the investigation with this documentation.

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: NA

Action taken by facility:

No action taken.

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
Houston County Attorney
La Crescent City Attorney
La Crescent Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33651	A. BUILDING: _____ B. WING _____	C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK VILLAGE LACRESCENT	1384 COUNTY ROAD 25 LA CRESCENT, MN 55947

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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: #HL336513620C/#HL336513421M On May 13 and May 14, 2024, the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. At the time of the onsite visit there were 54 residents receivinng services under the Assisted Living Facility with Dementia Care license. The following correction order is issued/orders are issued for #HL336513620C/#HL336513421M, tag identification: 0620, 1620, 2310, and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment regarding the death of a resident entrapped in a siderail. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). Findings include: R1 began receiving services on May 25, 2021.	0 620		

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0 620	Continued From page 3 R1's diagnoses included osteoarthritis (degenerative joint disease), congestive heart failure (heart cannot pump blood well enough), and polyneuropathy (multiple nerves that are damaged). R1's service plan dated April 1,2024, indicated R1 received services including medication management, vital signs, and assistance with compression stockings. A resident incident report dated April 29, 2024, at 9:00 a.m., indicated an unlicensed personnel (ULP)-F went in to R1's room to administer medications and complete a blood sugar check. ULP-F found R1's lower half of her body on the floor with her neck and head stuck between the mattress and bedrail. R1 was unresponsive. ULP-F called 911 and removed R1's head from the siderail and lowered her to the floor. When law enforcement arrived on scene, they attempted cardiopulmonary resuscitation (CPR) while waiting for a copy of the resident's wishes for life support. When emergency medical services (EMS) arrived R1 was pronounced dead at the scene. ULP-F then contracted the facility nurse. During interview on May 14, 2024, at 9:58 a.m., registered nurse (RN)-B stated ULP-F contacted her and explained what she had found when she walked into R1's room that morning and stated R1 was deceased. RN-B stated she did not file a Minnesota Adult Abuse Reporting Center (MAARC) report as the facility was following R1's service plan and nothing could have been differently to prevent the incident. RN-B stated they do not file a MAARC report if everything is followed according to service plans and policies. RN-B stated the facility did not do anything wrong. The facility provided policy #7003, Abuse and	0 620		

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0 620	Continued From page 4 Neglect/Vulnerable Adult, dated October 3, 2019, home care staff are provided training regarding internal reporting of suspected maltreatment and their obligations to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). All employees are mandated reporters of any suspected abuse or neglect of a vulnerable adult. The Director of Nursing and/or designee and the Executive Director are the facility designated reporters. This same policy gives the definition of neglect as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The facility's policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, dated August 1, 2021, indicated the facility developed individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		
02310 SS=L	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 record review and interview the licensee failed to provide services based on accepted health care standards when it did not	02310		

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02310	Continued From page 5 ensure the siderail on the resident's bed were applied according to manufacturer's directions were followed for one out of one (R1) reviewed. The licensee also failed to document maintenance of R1's siderail. Within a week after returning from a hospitalization with changes to R1's medication regimen, R1 was found dead with her head and neck lodged between a siderail and her bed. This deficient practice potentially affected all residents with siderails in use. Additionally, based on observation, record review, and interview as described above, the licensee had twenty-three residents using siderails (R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, and R24) who could be impacted by this deficient practice. This practice resulted in a level four violation (a violation that results in 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). The findings included: The U.S. Food & Drug Administration (FDA) website dated February 27, 2023 titled Recommendations for Health Care Providers Using Portable Bed Rails indicated the following regarding bed rails Make sure the individual is an appropriate candidate for bed rails due to risk of entrapment Review warning labels and instructions for use provided with the bed rails Be aware that not all bed rails, mattresses, and bed frames are interchangeable and not all bed	02310		

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02310	Continued From page 6 rails fit all beds. Check with the manufacturers to make sure the bed rails, mattress, and bed frame are compatible. Follow the health care facility's procedures and manufacturer's recommendations and specifications for installing and maintaining bed rails for the particular bed frame and bed rails used. 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. When in doubt, call the manufacturer of the bed rails for assistance. The U.S. Food & Drug Administration (FDA) document titled Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities, and Home Care Settings dated April 2023 indicated the following regarding bed rails: Avoid the automatic use of bed rails of any size or shape Inspect, evaluate, and maintain beds, mattresses and bed rails to identify and remove potential fall and entrapment hazards considering all relevant risk factors Ensure rails fit closely enough to the mattress to prevent entrapment If a patient, family member, or authorized representative requests the use of side rails, the interdisciplinary care team has a responsibility to	02310		

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02310	Continued From page 7 discuss the risks involved, as well as the benefits of any clinical and/or environmental interventions that may be safer in meeting the patient's assessed need The patient's right to participate in care planning and make choices should be balanced with caregivers' responsibility to provide care according to an individual assessment, professional standards of care, and any applicable state and federal laws and regulations. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items should be ongoing The mattress to bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering. Check for compression of the mattress' outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail. R1 R1 admitted on May 25, 2021, R1's diagnosis included osteoarthritis (degenerative joint disease), congestive heart failure (heart cannot pump blood well enough), and polyneuropathy (damage to multiple nerves). R1's care plan dated April 1, 2024, indicated R1 required assistance for putting on and taking off compression stockings, medication administration, and weekly vitals. The resident's assessment indicated she used a four-wheeled walker and was independent with transfers and getting in and out of bed. R1's siderail use assessment dated January 12, 2024, was completed by an LPN, and subsequently co-signed by RN on January 15, 2024. The assessment indicated the resident	02310		

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02310	Continued From page 8 had a history of falls and difficulty with bed mobility and going from a lying position to a sitting position in bed. The assessment indicated the resident currently had a siderail on the bed for positioning and support. This same assessment indicated interventions of positive and negative aspects of siderail use had been discussed with the resident and are aware of the risks involved with siderail use although the document did not indicate what the specifics risks were to the resident. R1's medication administration record (MAR) for the month of April 2024, indicated R1 was administered furosemide 20 milligrams(mg) tablet by mouth twice a day for water retention from April 1 through April 17. This same record indicated R1 was not given her dosage of medication from April 18 through April 22 [due to hospitalization]. R1's comprehensive assessment dated April 22, 2024, which was completed by a licensed practical nurse, and subsequently co-signed by a registered nurse on April 30, 2024, indicated the resident did not require safety checks but was at moderate risk for falls and used half-siderail on her bed for mobility. The same document indicated the resident use half siderails for get in and out of bed. The same form included an entry indicating the responsible party indicated by R1's initials was dated May 10, 2022. The same document included "recommendations" which indicated "bilateral" and siderails to promote independence also dated May 10, 2022. R1's comprehensive assessment dated April 22, 2024, indicated R1 had returned to the licensee following a hospital stay for CHF and history of shortness of breath, weight gain, and swelling of	02310		

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02310	Continued From page 9 the legs. R1's progress note dated April 25, 2025, indicated R1 had recently returned from hospital stay and unable to walk long distances. The same note indicated a therapy evaluation order was obtained. R1's MAR for the month of April 2024 indicated R1 was prescribed, and the licensee administered, an increased dose of from furosemide 20 mg twice a day to furosemide 40 mg twice a day. The April MAR indicated the licensee administered this new higher dose on April 23, 2024, through April 27, 2024. R1's monthly check dated April 25, 2024, included a set of vital signs whose results shows a blood pressure of 104/70 and a pulse of 62. The same document under the topic of location, duration, and intensity of pain lists feet, legs, and knees but includes no further information. A review of R1's medical record identified no other follow-up to these findings. R1's progress note dated April 28, 2024, indicated R1 had deceased that morning. The same note indicated the cause of death was "not sure" while indicating R1 was found with her head stuck in her siderail. An incident report dated April 28, 2024, indicated R1's body was on the floor next to her bed with her head and neck stuck in between the mattress and the siderail. R1 was described as unresponsive. The same document indicated 911 was called and a licensee caregiver raised R1's head out of from the siderail and the mattress. R1's death record listed the immediate cause of	02310		

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	33651	A. BUILDING: _____ B. WING _____	C 05/14/2024

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02310	Continued From page 10 death as positional asphyxia [suffocation]. R1's autopsy indicated she had multiple contusions along the neck and the left neck furrow while noting R1 was found with her neck "compressed" between a siderail and a bed. The same document included a description of "blunt force" injuries to R1's neck and torso. According to this document, R1 died as a result of positional asphyxia. An image provided by the medical examiner office showed R1 deceased on the floor next to the bed with the siderail on the same side of the bed visible. The image also shows another siderail near the foot of the bed on the left side of the bed. A review of R1's medical record showed no reference to the siderail at the foot on the left side of the bed. During an interview on May 13, 2024, at 2 p.m., licensed practical nurse (LPN)-E stated R1 had a full-size bed with a 1/4 length grab bar belted to the bed to secure the siderail. During an interview on May 14, 2024, at 8:00 a.m., family member (FM) stated R1 had a twin-size single bed with two siderails. FM-D stated R1 brought the one siderail with her when she was admitted to the licensee and that was the bar R1 was entrapped in. FM-D stated the grab bar was located on the right side of the bed which was the side R1 entered and exited bed. FM-D stated she did not know who installed the siderail as she assumed R1 did. FM-D stated there was also a small step stool for R1 to use as the bed was too tall for her to get in and out without it. FM-D stated there was a rail on the	02310		

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02310	Continued From page 11 other side of the bed, but she did not know where that came from. During an interview on May 14, 2024, at 11:20 a.m., housing manager (HM)-A stated the siderails are not handled or maintained by maintenance. HM-A stated the licensee is responsible for moving the resident and hires a moving company to assist in that move and could not say who put the siderail on R1's bed at the time of the move. HM-A stated he was not personally familiar with the actual siderail on R1's bed. The licensee's 6.27 Side Rails, dated August 1, 2021, indicated staff from Springbrook Village will determine if the side rail is considered to be safe. The same document indicated safe shall be defined as meeting all of the requirements listed which included: Siderails used consistent with manufacturer's direction Siderails are installed securely Siderails are maintained in good operating condition and to be aware of "wobbly" side rails. Siderails are consistent with the FDA's 2006 recommended measurements to reduce entrapment. The same document indicated residents shall be informed of the risks and benefits of the use of siderails and education provided will be documented in the resident record. The same document indicated the licensee would inform local hospice providers and known medical equipment suppliers that residents will only be permitted to use siderails that comply with 2006 FDA dimensional to reduce entrapments.	02310		

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02310	Continued From page 12 On May 15, 2024, at 9:58 a.m., the investigation included a request the facility provide a copy of the manufacturer's direction and any documentation of the facility's maintenance records of the siderail located on R1's bed. The facility did not provide the investigation with this documentation. R2-R24 On May 13, 2024, at 8:41 a.m., during a tour of the facility evaluator observed seven beds in memory care unit one to have some sort of bedrail on their bed. On May 13, 2024, at 9:30 a.m., evaluator along with an unlicensed caregiver toured memory care unit two and found ten rooms to have some sort of bedrail on their bed. On May 13, 2024, at 12:30 p.m., evaluator along with LPN-E entered each apartment of a resident who had a siderail on their bed. LPN-E was asked to measure siderails and indicate which residents were on hospice cares. Twenty three out of fifty four residents residing at the facility were found to have siderail(s). The investigation included a request via email on May 13, 2024, at 1:10 p.m., for all residents identified by the facility with siderails in place. A review of the documentation provided by the facility indicated there were twenty three residents with bed rails. Of those twenty three residents ten were on hospice with hospital beds, six of the residents had hospital beds but were not on hospice, and the remaining seven using non-hospital beds with rails. Those residents were identified as (R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14,	02310		

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02310	Continued From page 13 R15, R16, R17, R18, R19, R20, R21, R22, R23, and R24) who used siderails and could be impacted by this deficient practice. TIME PERIOD FOR CORRECTION: 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: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	Please refer to public report for details. For the specifics of the non-compliance regarding R1, please see correction number 2310 of this docuent.	