STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Towers of Rochester Inc	4001 19th Avenue Northwest Rochester, MN 55901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to provide adequate supervision for R2. This resulted in an immediate jeopardy (IJ) for R2 who was identified as an elopement risk and was able to leave the facility through a fire door without staff knowledge. R2 was last seen on August 14 at 9:15 p.m. and found approximately two blocks away from the facility and brought back to the facility by police at 11:13 p.m. Staff was unaware that R2 had eloped due to the the door alarm not sounding. The IJ began on 8/14/24 when R2 eloped from the facility. The IJ was identified on 8/23/24. The Director of Nursing was notified of the IJ on 8/23/24 at 3:10 p.m. The IJ was removed on 8/15/24 and deficient practice was corrected on 8/16/24, prior to the start of the survey and was therefore past noncompliance. Findings include: R2's observation for elopement risk dated 7/30/24, indicated R2 recently had changes in medications and recently moved to the facility. R2 was disoriented. His elopement risk was low. R2's care plan dated 8/1/24, indicated R2 exhibited wandering (moves with no rational purpose, seeming oblivious to need or safety). Wander guard (an arm bracelet which notifies staff if resident leaves the premises) placed to wrist to alert staff to exit seeking behavior. R2's physician order sheets dated 8/5/24, indicated R2 had placement of a wander alert system. R2's progress note dated 8/14/24 at 12:23 p.m. indicated R2 walked to the fire door and set off the alarm. Staff responded and let him back in. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's observation of elopement event dated 8/15/24, indicated R2 had successful and unsuccessful elopement attempts in the past. R2 wandered with no rational purpose and attempted to open the door. R2 was found in a parking lot of a large retail store. R2 had dementia and Covid-19. R2's interventions were 15-minute checks with a paper log. A progress narrative note indicated on 8/14/24 at 12:23 p.m. R2 walked to the door and set off the alarm. Staff responded and escorted him back in. On 8/14/24 at 11:56 p.m. documentation indicated at around 11:13 p.m. a police officer arrived at the facility at the main entrance using the nursing doorbell. The writer and another nurse approached the officer and asked if they knew R2. The officer stated he found him around 11:04 p.m. at a large retail store. R2 wasn't able to explain how he left the building or which door he used. Skin assessment was completed with no concerns. R2 was placed on 15-minute checks. R2's wander alert on his right wrist was checked at 12:00 a.m. and was not working. The writer had last seen R2 from 7:30-7:50 p.m. giving medication. R2's family was left a voicemail. No alarm was heard by the staff to notify them there was an elopement. Maintenance was called after R2 returned and writer expressed concerns of the doors not being properly secured. Maintenance came out and checked the door. The director of nursing (DON) and the on-call nurse were notified of the incident. Staff were educated on resident being on 15-minute checks and a paper log was provided to the staff. R2's admission Minimum Data Set (MDS) indicated R2 had a Brief Interview for Mental status (BIMS) score of 9 indicating R2 was cognitively impaired. The MDS indicated R2 had wandering behavior 4 to 6 days, but less than daily. R2 required supervisor or touching assistance for transfers and walking. R2's pertinent diagnoses were Parkinson's disease, radiculopathy of the lumbar region (injured nerve roots in the lower back), and bradycardia (slow heart rate). Upon interview on 8/22/24 at 5:10 p.m. nursing assistant (NA)-B stated she had assisted R2 to get ready for bed on 8/14/24 at around 7:30 and did not see him after that. She stated she was aware of his elopement and was retrained on how to reset the door alarm. Upon interview on 8/23/24 at 8:45 a.m. the director of nursing (DON) stated he was called regarding the elopement on 8/14/24. The registered nurse (RN)-C told him R2 was returned to the facility by the police at around 11:13 p.m. He had returned safely with no injuries. RN-C stated the staff did not hear an alarm sound. RN-C placed R2 on 15-minute safety checks and requested the on-call maintenance staff to go onsite and assess the doors. The DON stated the root cause of the elopement was after R2 sounded the alarm on 8/14/24 at 12:30 p.m. the door was not reset. He stated the alarm has to be reset or the door alarm will not work. He stated the maintenance staff found that the door in R2's hallway, the same door he used for his attempted elopement, was not armed when he checked the doors during the night on 8/14/24. The following morning, 8/15/24 the DON reviewed video footage and the footage did not show R2 leaving the building. The DON collaborated with the camera company and found out the camera system had a 10 second delay. The DON further stated R2 had been given medications at approximately 7:30 p.m. by nursing and a nursing assisted viewed him around 9:15 p.m. R2's physician and family were notified. The facility provided an in-service/education on the elopement policy, wander guard system, egress door alarm system, temporary magnetic alarm, and the Wimplisafe alarm system on 8/16/24. Upon interview on 8/23/24 at 9:30 a.m. R2 stated it was a dark night and it was [NAME] outside. He stated he used a doorway and rode in the backseat of a car. He did not know what the wander guard around his was or what it was for and he couldn't recall why or how he left the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon interview on 8/23/24 at 12:11 p.m., the maintenance director stated one of his staff was on-call when the elopement occurred and went to the facility at approximately 1:00 a.m. He stated the following day he found out that R2 had sounded the fire door alarm on 8/14/24 around 12:30 p.m. and the maintenance department was not notified to reset the door alarm. He stated if the alarm is not reset it will not work. He stated since the elopement incident all staff were trained on how to reset the door. The facility also increased security so staff can see if a door was ajar on the television screens mounted in the hallways the same television that shows the staff which call lights are on. Upon interview on 8/23/24 at 12:33 p.m., registered nurse (RN)-A stated she was the nurse on call on 8/14/24 when R2 eloped. She stated R2 was a wanderer and had a wander guard placed on his wrist. She stated on 8/14/24 she heard R2 sound the fire door alarm at around 12:30 p.m. and saw that a nursing assistant was redirecting R2 back to his room. RN-A stated she was aware of how to reset the door when the alarm sounded, however found out following the elopement that nursing assistant staff had not been trained to reset the doors. Upon interview on 8/23/24 at 12:48 p.m. a maintenance staff worker stated on 8/14/24, he had worked in the facility until 9:00 p.m. At 11:45 p.m. he received a call from RN-C who told him a resident had eloped from the facility, was found about two blocks west of the facility and the door alarms did not sound. The maintenance staff member stated he arrived at the facility at approximately 1:00 a.m. He checked all the doors at the facility and found that door 6 was not alarmed. He stated he reset the alarm, checked it, and went home. The next day, through the facility investigation, he found out that R2 had sounded that alarm earlier on 8/14 and the alarm had not been reset. The NA who assisted R2 back to his room following the elopement attempt on 8/14/24 at 12:30, did not return a call during the survey. Upon interview on 8/23/24 at 4:19 p.m., nursing assistant (NA)-A stated R2 was a wanderer. She stated the evening he eloped from the facility she had walked past his room at approximately 9:15 p.m. and R2 was seated in the chair in the corner of his room looking out into the hallway. A facility policy titled Elopement dated 2018 indicated the facility was to provide a safe and least restrictive environment for resident. To maintain the safety of residents who are at risk of wandering and/or active elopement. This IJ was called at past non compliance due to action the facility took prior to survey entrance. Actions taken included, all staff were educated on how to reset all the doors at the facility, the door alarm company was onsite the following day and checked all the tags for the all the doors, equipment was added that allowed the staff to see any door that an alarm had gone off on the televisions, the facility updated their camera system post motion on the video from the default of 3 seconds to 10 seconds.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to attempt to try alternative devices before using bedrails on resident's beds for 7 of 7 resident (R1, R2, R3, R4, R5, R6, R7) when the facility failed to accurately assess the resident for risk of entrapment by assessing residents medical diagnoses, size and weight, cognition, communication, mobility, and risk of falling. In addition, the facility failed to provide ongoing assessments to assure the bedrail is used to meet the resident's needs. Findings include: Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 dated October 2023 indicated a physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident. R1's annual Minimum Data Set (MDS) dated [DATE] indicated R1 was cognitively intact. R1 did not have any behaviors. R1 was dependent in rolling left to right, transferring, dressing and personal hygiene. R1 was frequently incontinent of bowel and bladder. R1's pertinent diagnoses were Parkinson's disease, osteoarthritis, and chronic congestive heart failure. R1 was taking an anticoagulant and a diuretic. R1's MDS did not indicate she had a bedrail in place. R1's restraint/adaptive equipment use observation form dated 9/18/23 indicated R1 had side rails. R1 was taking diuretics and sedative/hypnotics. R1 was to use the quarter assist bars for bed mobility in bed. The form indicated the siderails were not a restraint. No alternative devices were attempted. No other Restraint/Adaptive Equipment observations were completed in R1's medical record. Upon interview on 8/22/24 9:15 nursing assistant (NA)-C stated he had worked at the facility for about a year and R1 was never able to move herself in bed with or without the bedrails. He stated it took two staff to hold her on her sides. Upon interview on 8/22/24 at 11:29 a.m. NA-D stated R1 did not use the bedrails when the NA's were caring for her. She was a heavy total assistance of two, she could not reposition herself. Upon interview on 8/22/24 at 3:18 p.m. family member (FM)-A stated R1 did not use the bedrails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon interview on 8/26/24 at 9:09 a.m. registered nurse (RN)-B stated R1 was dependent on two staff members to assist her with bed mobility. She was not certain if R1 could assist with any mobility. She stated R1 had not had an observation for the side rails since 9/18/23 and she stated R1 had declined since that date. RN-B did not believe R1 could physically remove the bedrails by herself. She was unaware of any devices attempted and failed for R1. R2's admission Minimum Data Set (MDS) indicated R2 had a Brief Interview for Mental status (BIMS) score of 9 indicating R2 was cognitively impaired. The MDS indicated R2 had a wandering behavior of 4 to 6 days of the 7-day assessment periods, but less than daily. R2 required supervisor or touching assistance for transfers and walking R2's pertinent diagnoses were Parkinson's disease, radiculopathy of the lumbar region (injured nerve roots in the lower back), and bradycardia (slow heart rate). R2's MDS did not indicate if he had bedrails on his bed or not. R2's care plan dated 8/8/24 indicated R1 had cognitive loss/dementia. R1 exhibited cognitive loss, no diagnosis of dementia, has Parkinson's disease, delirium in hospital. BIMs score of 5 on admit. R2's care plan dated 8/15/24 did not indicate R2 had quarter bedrails on his bed. R2's Restraint/Adaptive Equipment Use Observation document dated 7/30/24 indicated R1 had siderails and grab bars. The observation did not indicate R2 had behavior symptoms, which included wandering and wore a wander guard (a bracelet which alerts staff when residents have attempted elopement). The form indicated that no alternative to the bedrails or grab bars were tried in the past. The form indicated the device met the definition of a physical restraint with no further documentation. The siderails were to be used for decreased mobility when R2 was in bed to assist with transfers, bed mobility and boundary limitations. Upon observation and interview on 10:20 a.m. R2 had quarter side rails in his room. R2 was unable to state what the siderails were and what they were to be used for. Upon interview on 8/26/24 at 10:55 a.m. RN-A stated she was not certain of R2's cognition since had a different BIMs score on his MDS versus his care plan. R2's MDS dated [DATE] indicated his BIMS scare was a nine and his care plan dated 8/8/24 indicated his admission BIMs was a five. She stated she believed R2 used the bedrails to transfer in and out of bed. RN-A denied trying any alternative devices for R2 and did not believe that PT tried any other methods as well. She stated R2 was a wanderer and he had wandered into other residents' bedroom. R2 sounded the fire door alarm on 8/14/24 and later that same day of 8/14/24 eloped without recollection. RN-A was not certain if R2 understood the bedrails or if he could remove then easily. R3's care plan dated 9/6/23 indicated R3 displayed the following behaviors related to yelling out and verbally abusive toward others. Staff was to distract resident when an upsetting situation develops. If R3 became aggressive staff was to leave room and return later. If resident became delusional staff was not to challenge the situation. If resident became verbally aggressive staff was to respond calmly and not raise their voice. Staff was to remove objects that might be used to harm resident or others. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's quarterly MDS dated [DATE] indicated R3 had a BIMS score of 3 indicating severe cognitive impairment. R3 was not identified as having any behaviors. R3 required maximum assistance to roll from left to right in bed. R3 was dependent with all transfers. R3 was always incontinent of bladder and frequently incontinent of bowel. R3's pertinent diagnoses were chronic kidney disease, spastic hemiplegia affecting right dominant side (muscles on one side of the boy being in a constant state of contraction and dementia. The MDS indicated R3 did not have a bedrail in use. R3's Restraint/Adaptive Equipment observation form dated 8/23/24 (completed the during the survey process) indicated R3 had bilateral grab bars. The form indicated R3 had no behaviors. R3 was taking antidepressant and diuretics. The device would be used while R3 was in bed. The form did not indicate if any alternatives to the current device had been tried in the past, if based on the findings if the use of the device supported by appropriate reason for use or if based on the findings the device was safe for the resident. The form did not classify the grab bars as side rails, they were classified as adaptive equipment. The form did not include any behaviors for R3. Upon interview on 8/26/24 at 9:09 a.m. RN-B stated maybe R3 could hold one of the bedrails with his left hand only during a repositioning with staff if staff asked him to. When R3 was on his own in bed cognitively he would not have been able use the bedrail to reposition. R3 could not remove the bedrail himself. No other alternative devices were attempted. R4's Restraint/Adaptive Equipment observation form dated 8/13/24 indicated an admission assessment for bed rails was completed. No other information was documented on the form. Including the type of device, behaviors, alternative methods attempted, falls, when and why a device was used, falls and if the device was a restraint. R4's quarterly MDS dated [DATE] indicated R4 had a BIMS score of 15 meaning she was cognitively intact. R4 had no behaviors. R4 required moderate assistance to roll in bed and with all transfers. R4's pertinent diagnoses were congestive heart failure, Type 2 Diabetes, and osteoarthritis. R4 did not have a bed rail. R4's Restraint/Adaptive Equipment observation form dated 8/23/24 (during the survey process) indicated R4 had bilateral grab bars. The form did not identify R4 as having any behaviors. R4 preferred to have the grab bars to aid in repositioning when she was in bed always. The grab bars were not classified as siderails, they were classified as adaptive equipment. No alternative devices were tried in the past. Upon interview on 8/26/24 at 9:09 a.m. RN-B stated she did not believe that R4 could physically remove the bedrails. She denied any alternative devices attempted. R5's Restraint/Adaptive Equipment observation dated 7/25/23 indicated R5 had siderails. No alternative devices were attempted. The type of side rail was a top half used for assistance with transfers and bed mobility. R5's quarterly MDS dated [DATE] indicated R5's BIMS score was a five indicating she had severe cognitive impairment. R5 had no behaviors. R5 required extensive staff assistance with bed mobility. R5 had a pressure relieving mattress. The MDS did not indicate if R5 had a bedrail. R5 had no concerns with skin conditions. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon interview on 8/26/24 at 9:09 a.m. RN-B stated R5 would be able to follow directions if staff guided her to use the siderail during her cares, but not on her own. She stated R5 cognitively would not be able to remove the bedrails on her own. An alternative device was not attempted for R5. R5's last Restraint/Adaptive Equipment observation was over a year ago. RN-B stated she believed assessments were to be done quarterly by the MDS nurse. R6's care plan dated 7/17/23 indicated R6 was on the turning and reposition program due to decreased mobility with assistance and grab bars in bed and one staff member. R6 could not always verbally ask for assistance. R6's care plan dated 8/2/23 indicated R6 required the assistance of two staff members while in bed. R6's care plan dated 6/20/24 indicated R6 was admitted to Hospice for a terminal diagnosis. R6 was taking antidepressant and antianxiety medications. R6's quarterly MDS dated [DATE] indicated R6 had a BIMS score of 0 indicating severe cognitive impairment. R6 had no behaviors. R6 required extensive assistance with bed mobility and transfers. R6 had a pressure relieving mattress on her bed. The MDS did not indicate if R6 had a bedrail. R6's care plan dated 8/17/24 indicated R6 had a perimeter mattress to define edges and prevent falls. R6's Restraint/Adaptive Equipment observation form dated 8/22/24 (completed during the survey process) indicated. R6 had side rails. R6 had no behaviors, she was taking narcotics. She had a resident decline in medical condition. She used the bed rail for bed mobility. No alternatives to the current device had been tried in the past. The form did not indicate whether the device was safe for R6 at this time, or the side rails were a restraint. Upon interview on 8/26/24 at 9:09 A.M. RN-B stated R6 was on hospice and would not be able to remove the bedrail by herself cognitively or physically. She did not believe that R6 was using the bedrail, but maybe she was holding onto it when the nursing assistants, (NA) were providing care. R6 did not have a Restraint/Adaptive Equipment observation prior to 8/22/24 during the survey process. R7's admission MDS dated [DATE] indicated R7 had a BIMs score of 3 indicating she had severe cognitive impairment. R7 did not have any behaviors. R7 was dependent with rolling in bed and with all transfers. R7's pertinent diagnoses were dementia, chronic obstructive pulmonary disease, Kienbock's disease (a disease of the wrists where the bone deteriorates and causes pain and swelling), and osteoporosis. R7's MDSH did not indicate R7 had bedrails on her bed. R7's care plan dated 8/1/24 indicated R7 used a Hoyer lift for all transfers. R7 required the assistance of two staff for bed mobility. R7 could not verbally ask for assistance. R7 was on the turning and repositioning program due to decreased mobility every 2-3 hours. R7 had a floor mat while she was in bed and frequent checks in bed due to a history of falls. Care plan did not indicate R7 had bedrails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon interview on 8/26/24 at 10:55 a.m. RN-A clarified that R7 was a newer admission and did have siderails. She stated with a BIMs of 3 R7 was not able to remove the bedrails on her own. She stated no other devices were attempted. Upon interview on 8/23/24 at 11:15 a.m. the regional nurse stated the nursing managers are to be assessing the bedrails quarterly per the facilities policy. She was not aware that alternative device methods were required prior to the use of bedrails. Upon interview on 8/26/24 at 11:55 a.m. physical therapist (PT)-A stated she look at mobility when she is assessing a resident, whether they can get out of bed or not. She stated there was only a handful of residents at the facility who did not have bedrails. PT-A stated the therapy department does not try alternatives. She stated bedrails and siderails are defined as rails placed on a bed for mobility and grab bars silver bars that are mainly hung in the bathrooms to assist with mobility. A facility policy titled Bedrails dated 2018 indicated prior to installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include verbal cuing, PT/OT evaluation, strengthening exercises, over-bed trapeze and other mobility and positioning strategies. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: -An evaluation of the alternatives to bedrails that were attempted and how these alternatives failed to meet the resident's needs. -The residents risk associated with the use of bedrails, input from the resident and/or representative and consultation with the attending physician. -Before using bedrails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with the bedrails and obtain informed consent. The following information will be included in the consent: -The assessed medical needs. -The residents' risks from the use of bed rails and how those will be mitigated. -The alternatives that were attempted but failed to meet the resident's needs -The alternatives that were considered but not attempted and the reasons. Any use of side rails will meet the FDA guidelines to reduce entrapment risk.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to conduct regular inspections of all bed frames, mattresses, and bedrails as a part of the regular maintenance program to identify areas of possible entrapment. All of the residents at the facility have the same beds. The facility census was 55 and 50 of those residents had the same quarter siderails on the beds. The bed manufacturer guidelines indicated to visually inspect the bed and accessories monthly. This failure had the potential to affect 50 residents in the facility. Findings include: A side rails safety environment inspection form dated 9/20/22 indicated one resident with bedrails was assessed with revisions made and again on 5/24/24 one resident with siderails was inspected with revisions made. Upon observation on 8/23/24 at 10:10 a.m. all residents' rooms at the facility were observed for bedrails. Fifty residents had beds with quarter sized bedrails attached by the head of the bed and five residents did not have any bedrails. The bed manufacturer guidelines indicated maintenance/inspection information: Visually inspect the bed and accessories for broken welds or cracks and check for loose hardware on a monthly basis. If any broken welds or cracks are found remove bed from service immediately and replace affected parts or contact technical support and tighten any loose hardware. Upon interview on 8/23/24 at 11:15 a.m. the regional nurse stated she believed maintenance inspects the bedrails quarterly. She stated she would provide documentation. She provided a log of a bedrail assessment dated [DATE] completed during the survey process for one resident. Upon interview on 8/26/24 at 9:09 a.m. registered nurse (RN)-B, nurse manager stated the nursing department does not inspect the bedrails. If the nursing staff noticed a concern with any bedrails the staff would notify the maintenance department. She was not aware how often maintenance inspected the rails. Upon interview on 8/26/24 at 9:29 a.m. the director of maintenance stated the beds are inspected yearly. He stated the facility is only required to check one of the beds because all the beds are the same and bedrails to all of the beds are the same as well. Upon interview on 8/26/24 at 11:33 a.m. the director of nursing (DON) stated he did not consider the rails on beds to be bedrails. He stated he considered them to be grab bars. Defining a grab bar as a small bar attached to the bed and a bedrail would be taking up a quarter of a bed. He stated the appliance the facility used is only about a foot above the mattress and does not restrict residents therefor they are not bedrails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Towers of Rochester Inc	4001 19th Avenue Northwest Rochester, MN 55901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled Bed Safety and Bedrails dated 2022 indicated bedrails are adjustable metal or rigid plastic bars that are attached to the bed. They are available in a variety of types, shapes, and sizes. Bedrails included: side rails, safety rails, and grab/assist bars. The policy indicated siderails and mattresses are checked for entrapment concerns annually. Findings are documented. Maintenance will routinely inspect beds and related equipment to ensure proper function, identify risk and problems including potential entrapment risks.