STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gundersen St Elizabeth's Care Center	1200 Fifth Grant Boulevard West Wabasha, MN 55981

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to develop and implement a system to ensure ongoing, adequate monitoring for side effects with consumed psychotropic medications to promote continuity of care for 3 of 5 residents (R39, R56, R9); and failed to ensure the use of as-needed (i.e., PRN) psychotropic medication was limited to 14-days or extended to a certain date with supporting rationale provided by the medical provider for 1 of 5 residents (R31) reviewed for unnecessary medication use. Findings include: SIDE EFFECT MONITORING: R39 R39's annual Minimum Data Set (MDS) assessment dated [DATE], identified R39 had intact cognition and demonstrated no delusional thinking during the review period. Further, the MDS outlined R39 consumed both antianxiety and antidepressant medications. R39's Medical Plan of Care, dated 4/29/25, identified R39's medications and nursing orders with their corresponding start date(s). This identified R39 as being over [AGE] years old and having active orders for multiple psychotropic medications including: Wellbutrin (antidepressant) 300 milligrams (mg) daily with a start dated recorded 4/13/23; Trazodone (antidepressant) 50 mg twice daily (plus another 25 mg dose in the morning) with a start date recorded 6/21/24; Mirtazapine (antidepressant) 15 mg every bedtime with a start date recorded 9/26/24; and Lexapro (antidepressant) 15 mg daily with a start date recorded 3/25/25. On 5/21/25 at 7:57 a.m., R39 was observed seated in a recliner chair while in her room. R39 was interviewed and recalled consuming several medications for depression including Ativan and trazodone stating she felt, overall, the medications were fine but added aloud, They're going pretty good but I'm awfully tired. R39 stated she had felt really tired for the past several months and denied any other potential side effects of the medications. R39 stated staff were aware of her feeling tired and reiterated aloud, The Ativan and trazodone are the two that really make me sleepy. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R39's most recent Behavioral Health Consultant - Follow Up note, dated 1/2025, identified R39 was seen by an outside consultant for her mental and/or behavioral health needs at the care center. The note outlined R39 had sustained a fall that morning without injury and recalled the recent Holiday season. R39's family member stopped by during the visit and the note outlined, We discussed today patient's current status of anxiety as we have been monitoring this for the last several months. Patient expresses concern over sleepiness but has agreed it is in her best interest to maintain her current level of medication as it has been more comfortable than the feeling of anxiety. The note outlined some methods to help reduce anxiety for R39, such as more out-of-room activities, and concluded with dictation, Orders Placed, and, None. The completed note lacked any review of what, if any, potential side effects of the multiple consumed psychotropics were discussed, reviewed or evaluated with R39. When interviewed on 5/21/25 at 8:01 a.m., nursing assistant (NA)-F stated R39 was usually very anxious in the morning hours and would calm down as the day progressed adding R39 would often report she doesn't feel good and of being tired. NA-F stated R39 took medication to help her anxiety but the NA(s) don't record anything in the record about that such as symptoms or interventions, rather, they just pass it on to the nurses. NA-F stated they had never heard R39 complain about medication side effects before, but acknowledged R39 often reported being tired adding she enjoys lights off in her own room. R39's record included a series of notes labeled, BEHAVIOR MONITORING/PSYCHOTROPIC MEDICATION USE ASSESSMENT, and were dated 10/2024, 3/2025, and 4/2025. These notes outlined R39's psychotropic medications were adjusted in 10/2024 and 3/2025, and listed R39's current psychotropic medication regimen and interventions to address potential behaviors. The note dated 4/2025, identified a comprehensive registered nurse (RN) evaluation was completed, and recorded R39 as alert and oriented adding, . is her own person with decision making. R39's medications were listed and included Wellbutrin XL, Trazodone, Ativan and mirtazapine. The note outlined, Resident will state on a near daily basis that she doesn't feel good or that she is tired, generally she does well participating in activities and walking to the dining room to eat. However, all of these completed notes lacked evidence what, if any, potential side effects of the consumed psychotropic medications were being monitored or evaluated. R39's ADL Care Plan, dated 4/17/25, identified R39 was independent with ambulation and used a walker. A section labeled, Behaviors, identified R39 was anxious and would, at times, complain about a crawling stomach. R39's corresponding Care Plan, printed 5/19/25, identified R39's outlined problem statements, goals, and interventions along with date of onset and/or revision. This care plan identified, BEHAVIORS . may become very anxious and tearful, please reassure/redirect me as needed; provide 1:1 when able and PRN medication (if still available) when other interventions ineffective. The care plan continued, Nurses ------ I receive scheduled Wellbutrin XL, Lexapro and Trazodone and Ativan to help manage depressive symptoms and anxiety . administer as ordered and observe for effectiveness . Observe for potential s/s [signs] increased depressive symptoms . update NM/MD as needed. However, both of these provided care plans lacked what, if any, potential medication side effects were identified for R39 or being monitored despite R39 consuming multiple psychotropic medications. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R39's Med Pass AM flowsheet, dated 5/2025, identified R39's current physician-ordered medications and staff initials to demonstrate their administration and/or refusal. This identified current orders for Wellbutrin, trazodone, Ativan, and Lexapro with no refusals recorded. In addition, R39's corresponding Treatments/All flowsheet, dated 5/2025, identified R39's current nursing orders and treatments being completed along with staff initials to demonstrate their administration and/or refusal. This included a weekly skin assessment and a single flush to the ears for wax build-up; however, both the medication and treatment flowsheet(s) lacked evidence of what, if any, potential side effects with psychotropic medication were being monitored despite R39 having ongoing complaints of feeling tired. Further, R39's medical record was reviewed and lacked evidence of ongoing psychotropic medication side effect monitoring being completed to determine what, if any, effects had been identified or warranted ongoing monitoring despite R39 having potential effects (i.e., sleepiness). When interviewed on 5/21/25 at 8:39 a.m., RN-A verified they worked with R39, and explained when a psychotropic medication was adjusted then a short-lived order was placed on the MAR or TAR to monitor them for a response to the medication adjustment. However, this was more for behaviors and if they increased or decreased, and not for side effects of the medication. RN-A stated they were unsure when this was last completed for R39 and expressed it was just done if it showed on the MAR or TAR to be done and not on an ongoing basis. RN-A added, I couldn't tell you when I last charted it. RN-A stated they were unsure who or where ongoing side effect monitoring would be documented in the medical record. RN-A stated R39 complained everyday about being tired but R39 wanted the medications to continue as she'd rather be more tired without anxiety. On 5/21/25 at 10:52 a.m., the director of nursing (DON) was interviewed. DON verified they had reviewed R39's medical record and explained when a medication was adjusted then a short-lived order was placed to monitor the resident for their mood and behaviors. DON stated side effect monitoring was done by exception if noticed only. DON verified they were unable to provide documentation to show ongoing side effect monitoring but acknowledged the importance of monitoring for side effects to help ensure they don't worsen adding, We want to prevent those things. PRN MEDICATION: R31's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R31 had significant cognitive impairment. Diagnoses included progressive neurological condition, dementia, anxiety and depression. Medications received included an antipsychotic, antianxiety, antidepressant and opioid. R31's Care Area Assessment (CAA) dated 12/2/24 included psychotropic drug use. The CAA triggered related to resident having received scheduled antipsychotic medication, antianxiety and antidepressant medications. R31 received Seroquel (antipsychotic medication) twice a day and had previously received three times a day. R31 also received Buspar (used to treat anxiety) three times a day and sertraline (used to treat depression, panic disorders, and anxiety) every day. R31 also had an as needed lorazepam (used to treat anxiety and insomnia) and Seroquel available which were not used during the look back period. Administer as needed lorazepam when other interventions have been ineffective in controlling symptoms of anxiety. R31's Medical Plan of Care, last signed 5/7/25 included lorazepam 0.5 mg tablet by mouth every 4 hours as needed for anxiety. *No scheduled end date due to hospice*. R31's Medical Plan of Care was also signed on 3/26/25, 1/15/25, 10/30/24, and 7/11/24. The orders did not include a rationale to extend the medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R31'S Medication Administration Report (MAR) for 11/21/24 through 5/21/25 were reviewed. R31 received the lorazepam medication on 11/22/24, 12/7/24, 12/11/24, 12/19/24, 12/22/24, 12/27/24, 12/29/24, 12/30/24, 1/7/25, 1/9/25, 1/13/25, 1/17/25, 1/25/25, 2/13/25, 2/15/25, 2/16/25, 2/17/25, 2/21 through 3/7/25, 3/10 through 3/12/25, 3/22/25, 4/15/25, and 5/15/25. R31's plan of care dated, 4/25/25 included self care deficit related to dementia and weakness. Behaviors included a long history of anxiety and depression and receives medications for these. Will yell out help me which disrupts the living environment. R31 is calmer when wife is with him, or 1:1 staff. As needed medications have been helpful when other interventions were not effective. Reorient and reassure R31 as needed, approach in a calm manner, introduce self each time, explain what assistance is being provided, encourage participation in diversional activities, provide 1:1 as able and use as needed medications when available. Notify hospice, nurse manager or physician if frequency of as needed medication is increased and or anxiety increases. An interview and observation on 5/19/25 at 2:58 p.m., R31's family member (FM)-A indicated R31 gets sleepy after use of the as needed medication or change in his scheduled medication and has addressed this with the facility. FM-A stated things have gotten better over the past few months. R31 stated it is going okay here at the facility and is thankful FM-A is here frequently. R31 was sitting in his recliner and was alert and answering questions, but frequently looked to FM-A to answer questions. An interview 5/21/25 at 8:06 a.m., pharmacist (Pharm-A) stated all psychotropic medications required to have an end date and need to be reviewed by the provider prior to that end date even if they are a hospice resident. Pharm-A stated for as needed use for hospice they can go out six months as long as a rationale is included. Pharm-A stated she must have missed that on R31. An interview 5/21/25 at 8:30 a.m., registered nurse, hospice case manager (RN)-H, stated she is not aware of a requirement of end date of 14 days or need for rationale if extended longer for as needed psychotropic medications. An interview 5/21/25 at 9:23 a.m., registered nurse (RN)-B, stated generally as needed psychotropic medications require a renewal and face to face every 14 days. However, hospice has told the facility that isn't the case for hospice residents. RN-B stated the facility added the statement *No scheduled end date due to hospice* behind the order so staff are aware it isn't required. An interview 5/21/25 at 10:07 a.m., the director of nursing (DON) confirmed lorazepam is required to be renewed with face to face every 14 days even if residents are on hospice. Facility policy was requested for Psychotropic Medications use. A Consultant Pharmacist policy dated 12/17/24 was received and included the purpose is to provide pharmaceutical services in an accurate and safe manner with the collaboration between the pharmacy consultant facility leadership, facility staff, practitioners and the medical director to meet the individualized needs of the residents in this facility. The pharmacy consultant will complete at least a monthly medication regimen review for each resident in the facility and will meet all other responsibilities required of a qualified consultant pharmacist as set forth in any federal or state law, statues or regulations as enacted or as may be enacted or amended. R56 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R56's annual Minimum Data Set (MDS) assessment, dated 4/25/25, indicated R56 had intact cognition with no hallucinations or delusions and no behavioral symptoms including physical or verbal behavioral symptoms directed at others, or behavioral symptoms not directed toward others. Further, it indicated R56 received an antipsychotic and antidepressant medication. R56's May 2025 Medication and Treatment Administration Record (MAR/TAR), included the following orders: -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 2 milligram (mg) by mouth daily AM indicate for Use: other: severe episode of recurrent major depressive disorder, with psychotic features with a start date of 2/17/25. Medication was noted as administered 5/1/25 through 5/21/25. -Celexa (antidepressant medication used to treat depression) 20 mg by mouth daily Am indication for use: depression with a start date of 5/21/24. Medication was noted as administered 5/1/25 through 5/21/25. The document lacked evidence of side effect monitoring. R56's ADL Care plan, indicated the care plan was last updated on 4/14/25 and included the following information: - Please complete pivot transfer recliner to w/c (wheelchair) and w/c to recliner only. He will require A1 (assist 1) w/2ww (with 2 wheeled walker). Use EZ stand (mechanical lift) for all other transfers). ADL Care Plan lacks evidence of side effect monitoring. R56's Care Plan, included the following information: -transferring: 2 assist with use of EZ stand. 2/11/25 foal: sand pivot w/c to recliner. Please use 2 ww for pivot only for power w/c to and from recliner. EZ stand for all other transfers. -please administer my scheduled Celexa ordered, observe my for potential s/s of increased depression including social withdrawal, changes in my usual eating/sleep pattern. R56's care plan lacked indication R56 was prescribed an antipsychotic medication, possible side effects of antipsychotic medications, and monitoring of side effects of antipsychotic medication (i.e., tardive dyskinesia or orthostatic hypotension). Further, R56's care plan lacked identification of side effects of antidepressant medication and monitoring for side effects of antidepressant medication. R56's vital sign logs, for 2/25/25 through 5/20/25 were reviewed. The document lacked evidence of orthostatic blood pressures being completed. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R56's progress notes, for 2/25/25 through 5/202/25 were reviewed. Progress notes lacked evidence of side effect monitoring. R56's Behavior Monitoring/Psychotropic Medication Use assessment, dated 10/24/24, reviewed. The document identified R56 transfers with 2 assist and an EZ stand, and assessment being completed secondary to new medication order of Abilify (aripiprazole). The document lacked evidence of side effects to monitor for either antipsychotic or antidepressant medications. R56's Behavior Monitoring/Psychotropic Medication Use assessment, dated 4/24/25, reviewed. The document identified R56 had orders for aripiprazole and Celexa which was administered to R56. The document lacked evidence of side effects to monitor for either medication. During an interview on 5/19/25 at 3:21p.m., R56 was observed sitting in his room in his recliner. R56 was soft spoken but engaged in conversation. On 5/20/25 at 3:41 p.m., R56 was observed in his recliner in his room. R56 stated he was getting ready to take a nap. During an interview on 5/21/25 at 10:52 a.m., registered nurse (RN)-A stated when a resident starts on a psychotropic medication, side effects are monitored and charted as a progress note. RN-A was uncertain about ongoing side effect monitoring. RN-A stated when orthostatic blood pressures are to be checked there would be an order and it would be found on the MAR/TAR. RN-A reviewed R56's orders and MAR/TAR and verified there was no current order for obtaining orthostatic blood pressures. RN-A verified R56 had not had an orthostatic completed and documented since at least February 2025. RN-A stated R56 transfers with an EZ stand or a pivot transfer with staff assistance when going from his wheelchair to recliner. RN-A stated checking orthostatic blood pressures are important to ensure there isn't a drop in blood pressure putting residents at greater risk for falls and injuries. During an interview on 5/21/25 at 11:07 a.m., director of nursing (DON) stated documentation was completed more by exception meaning if something was wrong then it would be documented on. When asked specifically about side effect monitoring for psychotropic medications, DON stated don't technically monitor for side effects as we chart by exception. During a follow up interview on 5/21/25 at 11:46 a.m., DON stated he was unsure if it was recommended that orthostatic blood pressures be completed on residents who are on antipsychotic medications. DON stated the facility does orthostatic blood pressures after a resident falls or if there is a specific doctor order to complete them. DON stated orthostatic blood pressures are not being completed on residents who are taking antipsychotic medications. On 5/21/25 at 12:06 p.m., surveyor left consulting pharmacist (pharm)-A a voicemail message requesting a call back. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 5/22/25 at 9:56 a.m., pharm-A verified she was the consulting pharmacist for the facility. Pharm-A stated she was not sure if orthostatic blood pressures should be monitored when a resident was taking an antipsychotic medication. Pharm-A stated that the facility does a DISCUS (a dyskinesia identification system condensed user scale - monitors for tardive dyskinesia) every 6 months, when the medication is started to get a baseline and when the medication is discontinued. Pharm-A stated she has seen very few cases of TD (tardive dyskinesia), typically when someone who previously had TD, and with the new antipsychotics we see it less than with the older antipsychotics. R9's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R9 had intact cognition and demonstrated no delusional thinking during the review period. Further, the MDS outlined R9 consumed antidepressant medications. R9's Medical Plan of Care dated 12/18/24, identified R9's medications and nursing orders with their corresponding start date(s). This identified R9 as being over [AGE] years old and having active orders for multiple psychotropic medications including: -Trazodone (antidepressant, commonly used sleep aid) 150 mg daily at bedtime -Prozac (antidepressant) 30 mg daily in the morning R9's Care Plan, dated 12/18/24, identified R9 was unable to walk at this time due to onset of severe back pain. A section labeled Sleep identified R9 had trouble sleeping and would require Trazodone every night; notifying provider if R9 had trouble sleeping or irregular sleep pattern. A section labeled Medication identified R9 received Prozac for depression; monitor for effectiveness and side effects of these medications, report any significant changes in mood/behavior. A section labeled Behaviors identified R9 was sometimes noncompliant with medications and treatments; remind R9 the provider has ordered the medications and treatments and the benefits these provide. However, none of these care plans specified, if any, potential medication side effects were identified for R9 or being monitored despite R9 consuming multiple psychotropic medications. During interview on 5/20/25 at 10:39 a.m., nursing assistant (NA)-E stated, she isn't sure what side effects they would monitor for someone on a sleep aid, like Trazodone, because if it worked then the resident would be asleep. If the resident was still awake after taking the sleep aid then she would let the nurse know. NA-E stated, if a resident has a specific side effect to watch for, there would be an order and an area to chart in the treatment administration record (TAR). NA-E stated, she doesn't think any residents on the unit has side effects to monitor or chart on. During interview on 5/20/25 at 10:46 a.m., licensed practical nurse (LPN)-A stated, staff monitor side effects right after the resident starts a new psychotropic medication; usually 1-2 weeks are monitored. LPN-A stated, the side effects while a resident is taking a psychotropic medication include increase sleepiness, dizziness, agitation, problems with gait (walking), suicidal, or uncontrolled movements. LPN-A stated, most of the residents have been on these types of medications for a long time so they aren't being monitored for side effects. During interview on 5/21/25 at 10:52 a.m., director of nursing (DON) stated documentation was completed more by exception, meaning if something was wrong then it would be documented on. DON stated, don't technically monitor for side effects as we chart by exception. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility-provided Psychotropic Medication policy, dated 2/2024, identified residents would receive psychotropic medications when needed to treat specific conditions or symptoms. The policy continued, Nursing employees shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the provider [listed], however, the policy lacked how the campus would monitor for side effects with non-antipsychotic psychotropics (i.e., antidepressants, hypnotics); nor direction on where this monitoring would be documented within the medical record.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to identify and document the trauma-related history, post-traumatic stress disorder (PTSD), known triggers and lacked a system or process for completing trauma assessments for 1 of 1 residents (R59) with a known history of PTSD. Findings include: R59's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition with no behaviors. Diagnosis included post traumatic stress disorder and anxiety. R59 required partial to moderate assist for transfers, ambulation, toileting and personal hygiene. R59 was taking an antidepressant medication. R59's care plan dated 9/12/24, included a problem of self-care deficit related to activity intolerance, due to medical diagnoses. Resident history included he served in Vietnam. Behaviors included R59 may refuse cares at times and also forget to ask for assistance when needed. R59 may have crying episodes at times and doesn't like confined small spaces. A Behavioral Health Note dated 5/31/24 included a past psychiatric history of PTSD and readily engaged in testimony as to prior traumatic experiences. R59 has a substantial history of prior military traumas and personal losses which have been suppressed and managed through years of avoidance and distraction. R59's document review failed to include a trauma assessment or evaluation of R59's PTSD. R59's behavioral care plan failed to identify triggers or interventions related to managing R59's PTSD. On 5/19/25 at 6:05 p.m., R59 stated he served in the military and in Vietnam. R59 stated the Veterans Administration (VA) has treated him well for the most part. R59 stated he likes to be outside where he gets fresh air and when confined inside he feels sometimes like he can't get his breath. R59 would like staff to take him on walks outside more or at least just walk him outside of his room but it doesn't always happen and he feels like staff don't always listen to him. R59 was seated in his wheelchair in his room with oxygen on per nasal cannula. A walker was present. On observation 5/20/25 at 1:10 p.m., R59 was observed seated in a wheelchair in the sun room playing checkers with another resident. R59 did not have his oxygen on. On observation and interview 5/20/25 at 3:30 p.m., R59 was accompanied by nursing assistant, ambulating in the hallway with his walker with his oxygen on per nasal cannula. R59 smiled and said it feels good to be walking and be out of my room. On interview 5/20/25 at 1:37 p.m., social services (SS)-A stated she was aware R59 had a PTSD diagnosis but the facility only does mood assessments and a PTSD assessment would be done by a doctor or psychiatrist. SS-A stated they do not have a screening process in place for admissions for PTSD at this time. SS-A stated if someone has issues with PTSD we would do a behavioral care plan and do 1:1's with the resident. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 1:48 p.m., registered nurse (RN)-B stated nurses do not do a PTSD screen or assessment on admission. RN-B confirmed the care plan did not have any triggers listed, but she is aware he likes to be outdoors and doesn't like being stuck in his room with 4 walls. RN-B added R59 enjoys talking to other veterans, but only will talk about his PTSD when he wants to but not about actual events that happened. RN-B added R59 can walk on his own without staff present and frequently leaves his room on his own. On interview 5/20/25 at 2:43 p.m., RN-D stated he was not aware of R59's PTSD diagnosis and is not aware of triggers or interventions related to PTSD for R59. RN-D indicated generally he would look in the mood or behavioral care plan for triggers and interventions. On interview 5/20/25 at 3:38 p.m., nursing assistant (NA)-C and NA-D stated they were not aware of R59's PTSD. NA-C and NA-D stated they rely on other staff to let them know if they are having behaviors or not or look at the updated care plan in the book on the unit but that only covers activities of daily living like how many people to transfer, bath, etc On interview 5/21/25 at 9:38 a.m., RN-B stated the facility does not have a policy and procedure related to trauma informed care and provided Behavioral Assessments, Intervention and Monitoring policy and Abuse, Neglect, Mistreatment and Misappropriate of Resident Property policy and procedure. On 5/21/25 at 10:01 a.m., the director of nursing confirmed R59 did not have a PTSD assessment or plan of care and stated he was not aware of the trauma informed care regulations. A Behavioral Assessments, Intervention and Monitoring policy dated 12/12/24 included: - Upon admission, residents who display or are diagnosed with a mental disorder or psychosocial adjustment difficulty, or who have a history of trauma and or post-traumatic stress disorder will have referrals made for on-site or off-site psychiatric/psychological services. - Specific, individualized interventions will be put into place to aide in the behavior management that included non-pharmacological modalities. - The inter-disciplinary team will meet to review and discuss specific resident behaviors, appropriateness and effectiveness of interventions, current medications, psychiatric service recommendations. Resident behavior health needs will be addressed on the resident's person centered plan of care.

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Gundersen St Elizabeth's Care Center	1200 Fifth Grant Boulevard West Wabasha, MN 55981

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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** Based on observation, interview, and document review, the facility failed to ensure alternatives (i.e., small grab bar, positioning devices) were offered, attempted and recorded in the medical record prior to the use of bilateral one-half (1/2) side rails for 4 of 4 residents (R122, R45, R56, R222) observed to have side rails attached to their bed. Findings include: R122 R122's admission Minimum Data Set (MDS) assessment dated [DATE], identified R122 had intact cognition and demonstrated no delusional thinking during the review period. Further, the MDS included a section labeled, Section P - Restraints, which identified R122 used no bed rails. R122's Restraint Use Assessment, dated 5/9/25 and located with her registered nurse (RN) charting, identified R122 as admitting from the emergency department (ED) and having a history of heart failure, obesity, and diabetes. The evaluation outlined, Upon assessment of the resident, there is no current need for any restraints at this time as she is content with her admittance to the facility. The note concluded, . continue to monitor resident for any changes . However, on 5/19/25 at 2:51 p.m., R122 was observed lying in bed while in her room. R122's bed had bilateral, chrome-colored metallic 1/2 side rails on both sides of the bed which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. R122 stated she admitted to the care center the week prior from the hospital campus due to needing a ceiling lift for transfers. R122 stated staff had come into her room after she admitted and made me sign something about using the side rails, however, had never asked her about wanting them or not; nor any alternative devices (i.e., smaller grab bar) prior to installing them. R122 stated, rather, staff just showed up with them in the room and said 'can we install these?' to which R122 responded, Sure. R122 stated she used the rails to help with bed mobility, and she denied concerns or injury from these, thus far. R122's Consent for Use of Bed Rails/Assist Devices, dated 5/9/25, identified a written marking next to an option which read, Half (1/2) Rail, along with sections to outline potential benefits and risks with the use of the device. The form identified the rails were recommended due to two options listed as, Resident Choice/Security, and, Bed Safety. R122 signed the consent on 5/9/25, however, the spacing to have a staff member sign it was left blank. However, again, the form lacked evidence of what, if any, alternatives to a 1/2 side rail were considered, offered or discussed as a potential alternative to R122 prior to their installation. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R122's corresponding Resident Assessment, dated 5/9/25, identified a section labeled, Side Rails/Assistive Devices Assessment Required, with a checkmark placed to demonstrate an affirmative (i.e., yes) response. The section included four questions to be answered by staff with a checkmark placed next to either a, Yes, or, No, response. These questions were all marked to affirm R122 was able to demonstrate safe use of the rails, able to understanding the potential risks of them, able to use her call light appropriately, and the use of the rails would enhance the resident' mobility in bed or with transfers. However, the completed evaluation lacked evidence of what, if any, alternatives to a 1/2 side rail were considered, offered or attempted prior to their installation. Further, R122's ADL care plan, dated 5/14/25, identified R122 needed assistance of two with a mechanical lift for transfers. The care plan continued and identified R122 was independent with side to side bed mobility with only assist of one as needed (i.e., PRN). Further, the plan outlined a section labeled, Siderails, which indicated, 1/2 bilateral. When interviewed on 5/20/25 at 10:38 a.m., nursing assistant (NA)-A stated they had worked with R122 multiple times prior, and described her as pretty independent with most cares. NA-A explained R122 used a mechanical lift for transfers and, with bed mobility, expressed the staff helping her generally [had] to move her while in bed as R122 seemed to struggle in boosting herself up. NA-A verified R122 used bilateral side rails, and stated she had used them since admission adding, As far as I know. NA-A stated multiple residents used them and expressed the rails were more kept with the bed, not with the person from their understanding of them. NA-A stated they had never seen other devices, such as a trapeze or smaller grab bar, used on R122's bed since she admitted and, again, reiterated it was almost always just the bilateral side rails used on resident' beds. R122's medical record was reviewed and lacked evidence of what, if any, alternatives to a 1/2 side rail had ever been presented, evaluated, or offered to R122 prior to the installation of bilateral 1/2 side rails. On 5/20/25 at 2:28 p.m., the director of nursing (DON) was interviewed. DON verified R122 had 1/2 bilateral side rails attached to her bed and expressed they were used for positioning and not as a restraint. DON explained the nurses, upon admission, evaluate the need for them through their assessment process and obtain a physician order for them before their installed. DON stated he was unable to speak to the options which may have been presented to R122 instead of a side rail as he didn't complete the assessment, however, felt there were no other options (i.e., smaller grab bar, trapeze) even to use. When questioned on what, if any, alternatives to the side rails were ever offered to R122 either upon admission or since, DON responded, That I cannot speak to. DON stated they would discuss the matter with other nurses and obtain more information. During follow-up interview, at 3:32 p.m., DON verified they were unable to locate evidence in the medical record on what, if any, alternatives had been offered or considered prior to the side rails being installed. DON stated they reviewed the facility' policy on side rails and it did direct to check for alternatives prior, such as a trapeze, before the rails are installed. DON stated they were unsure what other alternatives the center had available to install, but acknowledged smaller bars or options may well work for residents. When interviewed on 5/20/25 at 3:45 p.m., the facilities manager (FMR) stated the center used two different types of bed, and maintenance was repeatedly taking rails on and off of them as residents would admit or discharge from the campus. FMR stated an assessment of the rail safety or any alternative would be completed by nursing adding their department (maintenance) just assumed that was done prior to them requesting the rails installed. FMR stated nobody from the care center had ever asked them about what, if any, alternatives were available adding, We were never asked to look into that. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R45 R45's significant Minimum Data Set (MDS) assessment dated [DATE], indicated R45 admitted to the facility on [DATE], had intact cognition and independent with transfers. The MDS indicated in section, P0100. Physical Restraints, that R45 had bed rails that were not used as restraints. R45's Consent for Use of Bed Rails/Assist Devices dated and signed by R45 on 9/11/24. The document listed benefits and potential negative outcomes of side rails. The document lacked any documentation or evidence of alternative methods/products attempted prior to the use of bed rails. Furthermore, the document had a section titled RECOMMENDATIONS: Based on physical and cognitive assessment, indications for the use of side rails or assistive devise are: resident choice/security, mobility bed safety, other which have boxes next to them to indicate. This area of the document was left blank. Furthermore, the document had a section TYPE OF RAIL/ASSIST DEVICE with small box next to the option to be marked to indicate what type of device to be used. The options included: quarter (1/4) rail, half (1/2) rail, Full rail, assistive device, and other. This area was left blank with no options marked. The consent for use of bed rails/assist device was not completed in full. R45's Resident assessment dated [DATE], indicated R45 was able to demonstrate safe use of the side rails/assistive device, verbalized understanding of potential risks, demonstrated the ability to use the call light appropriately for assistance and would use the side rails to enhance bed mobility or with transfers. A physician order dated 9/11/24 included an order for ½ (half) bilateral siderails. During an interview and observation on 5/19/25 at 3:35 p.m., R45 stated he has had bed rails since he moved into the facility last September which were observed to be on his bed. R45's bed had bilateral, chrome-colored metallic 1/2 side rails on both sides of the bed which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. During a follow up interview on 5/20/25 at 10:30 a.m., R45 stated he used the bed rails to prop himself up at night to use the urinal. R45 stated the bed rails had always been on the bed and did not know about any alternatives to bed rails. R45 stated the bed rails had always been a little loose and denied any concerns with this. R45 denied any injuries related to using bed rails at this time. During an interview on 5/20/25 at 2:33 p.m., director of nursing (DON) stated he cannot speak to how often assessments are completed for the use of bed rails but believed it would be upon admission and with a significant change or change of condition. DON verified R45's Consent for Use of Bed Rails/Assist Devices was not completed as the section for indication for use and type of rail was left blank and stated it should have been filled out completely. During a follow up interview on 5/20/25 at 3:33 p.m., DON verified he was able to review R45's medical chart. DON stated R45 did not have any alternatives attempted prior to installation of bed rails. R56 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R56's annual MDS dated [DATE], indicated R56 had intact cognition and required maximal staff assistance with bed mobility with an admission date of 5/21/24. The MDS indicated in section, P0100. Physical Restraints, that R56 had bed rails that were not used as restraints. R56's Consent for Use of Bed Rails/Assist Devices dated 5/21/24. The document listed benefits and potential negative outcomes of side rails. The document lacked any documentation or evidence of alternative methods/products attempted prior to the use of bed rails. A physician order dated 5/21/24 included an order for ½ (half) side rails to bed for mobility. During an interview and observation on 5/20/25 at 3:41p.m., R56 stated he has had bed rails since moving to the facility. R56 stated he uses them to get out of bed. R56 stated they have always been a little wiggly. R56 stated they have never been tightened since being attached to the bed nor had they become unattached when using them. R56 stated he has never tried or been offered any other devices to help with mobility beside the bedrails. R56's bed had bilateral, chrome-colored metallic 1/2 side rails on both sides of the bed which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. During an interview on 5/20/25 at 3:33 p.m., DON verified he reviewed R56 medical chart and stated R56 did not have any alternative attempted prior to the installation of the bed rails.R222 R222's admission Minimum Data Set (MDS) assessment, dated 5/15/25, indicated R222 had moderate cognitive impairment with no behaviors. R222 had no impairment to upper or lower body extremities, was set up assist for eating and oral cares, moderate assist for upper body and showering, and dependent on staff for lower body cares. R222 was independent with repositioning side to side, moderate assist with changing to and from lying to sitting, and dependent on staff for standing and transfers. The MDS also indicated R222 had no bedrails or alarms. R222 was enrolled in hospice care. R222's provider orders included morphine as needed for pain, lorazepam as needed for pain, anxiety, sleeplessness, shortness of breath, oxygen 3 liters per minute, and venlafaxine daily for depression. R222's admission careplan indicated R222 require 1 assist for activities of daily living, had no behaviors. During observation on 5/19/25 at 4:10 p.m., R222's bed had bilateral chrome half upper side rails attached to the frame of the bed at one attachment point. The grab bar was loose. During interview on 5/19/25 at 10:50 a.m., R222 stated she uses the side rails to reposition in bed and help her sit up. R222's side rail assessment dated [DATE] was marked N/A. R222's restraint use assessment progress noted dated 5/9/25 indicated No restraints recommended. Resident declines wanting to use side rails at this time. Will re-evaluate as needed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 5/20/25 at 12:58 p.m., nursing assistant (NA)-A stated R222 can reposition self and does not use side rail often. NA-A stated the beds come with the side rails. They can be detached upon request however are kept for safety's sake. During interview on 45/20/25 at 1:20 p.m., registered nurse (RN)-E stated R222 is able to make some position changes independently however does need assistance to sit up. R222 does use the side rails to help with positioning. RN-E stated resident's require a provider order for side rails which should be indicated in the medical plan of care. RN-E confirmed R222 does not have an order for side rails. RN-E then stated, you know what, it is careplanned. RN-E confirmed R222's careplan indicated no side rails. RN-E stated physical therapy usually assesses for the need for side rails upon admission. During interview on 5/20/25 at 1:29 RN-F stated R222's family stated they wanted R222 to have the side rails, however, they could not find a consent for the side rails in the hospice book or R222's hard chart. Facility policy, Proper Use of Side Rails/Assistive Devices, dated 12/2023, identified a purpose of ensuring the safe use of side rails and assistance devices. The policy outlined these would only be used to treat a medical symptom or to assist with mobility and transfers. The policy outlined, Less restrictive interventions that will be incorporated in care planning include . Providing a trapeze to increase bed mobility . Further, the policy outlined, Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails/assist devices.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure direct-care staff were trained and competent in the daily use of resident' medical equipment to ensure safety and reduce the risk of complication (i.e., device failure) for 1 of 1 resident (R53) who used a bed-side continuous positive airway pressure (i.e., CPAP) machine. Findings include: R53's admission Minimum Data Set (MDS), dated [DATE], identified R53 had moderate cognitive impairment but demonstrated no delusional thinking during the review period. The MDS outlined R53 had several medical diagnoses including atrial fibrillation, chronic kidney disease (CKD); and used a non-invasive mechanical ventilator while a resident at the care center. R53's Insomnia Assessment, dated 3/21/25, was recorded in her progress notes. This identified R53 denied any concerns with sleeping and used a CPAP device. On 5/19/25 at 3:05 p.m., R53 was observed seated in a recliner chair while in her room. R53's bed was positioned along the window and adjacent was a small bedside dresser which had a black-colored Resmed Airsense 10 CPAP sitting on top with an attached mask hooked onto the wall. R53 stated their significant other who visited the campus several times a week managed the device for her mostly and did the cleaning and maintenance of it for her. R53 stated the settings for the machine were pre-programmed by the significant other and staff usually just helped her turn it on to use. R53 stated the machine did, at times, have an issue or stop working with an alarm adding when that happens, she would ask staff for help with it. R53 stated she was unsure how knowledgeable staff were about the device though as some staff seemed to not know how to use it. R53 stated she started questioning staff now if they know how to use it before they touch it adding aloud, I ask them. When interviewed on 5/20/25 at 12:44 p.m., nursing assistant (NA)-B stated R53 was often not accepting of help with cares and likes to do her own thing. NA-B stated R53 used a CPAP at night adding she had done for since admission to the care center. NA-B stated the NA staff do nothing with it, however, rather the device was maintained by the nurses adding aloud, The nurses are supposed to manage that. R53's Treatments flowsheet, dated 5/13/25 to 5/20/25, identified a nursing order which read, . Cleanse CPAP daily in the AM and let air dry [am shift], with a listed start date, 03/21/2025. The order was signed off as completed each day during the period with staff initials. The provided flowsheet lacked any further information about the CPAP including settings the device should be at or any troubleshooting information about potential malfunctions or alarms which could activate. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 1:08 p.m., registered nurse (RN)-A was interviewed, and verified they were assigned care for R53. RN-A explained they had worked with R53 multiple times prior and described her as needing more help than she'd often allow for cares. RN-A verified R53 used a CPAP and nurses cleaned it, however, R53 would often re-assemble it before it was dry on her own. RN-A stated the settings were programmed into the device and the second shift was more responsible for the device, however, at times, they had to deal with the device adding a situation had happened just last week where they couldn't get the device to turn off. RN-A stated they had to call R53's significant other at home to triage and resolve the issue over the telephone adding they were concerned about screwing something up on the device. RN-A stated each CPAP machine was a little different and staff, at times, would almost have to YouTube it to learn how to use it. RN-A stated the facility had not provided them or any nurses with training on the CPAP device; nor was their a manual kept around about it adding aloud, I don't recall any. When interviewed on 5/20/25 at 1:40 p.m., the director of nursing (DON) stated there were several models of CPAP but all seemed to work on the same basic understanding and operation with function. When questioned on how these devices were taught to the direct care staff, then DON explained they used a model of a staff member learning the device, then teaching everyone else; however, DON stated they were unsure who was responsible to facilitate this model of teaching adding, That I can't speak to. The DON stated, I would hope they have some critical thinking skills and look it up online. DON stated it would potentially be difficult to teach every model of CPAP but acknowledged the devices were very important. DON stated most of their completed in-time training was done for equipment which had only one model type and voiced an example of their IV pump(s). DON reviewed the NEO (new employee orientation) checklist and verified it lacked training on CPAP device(s) or their use. DON stated they were unsure if a copy of the device' user manual was around the campus or not, however, added printing one off and having it available was likely helpful adding aloud, I like that idea. DON stated none of the direct care staff had expressed concerns about being unfamiliar with R53's CPAP prior and, if concerns were present, the staff could call a next level leader about it, too. DON acknowledged having staff trained and competent in the device was important just for safety and to reduce the risk of infection or complication. A provided CPAP (Continuous Positive Airway Pressure), Use of policy, dated 10/2024, identified general guidelines for the device which included, Only a qualified and properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask. However, the policy lacked information on what training would be completed by the care center to ensure competency with the device.

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F 0909 Level of Harm - Potential for minimal 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** Based on observation, interview, and document review, the facility failed to develop and implement a preventative, regular maintenance program of resident' beds and side rails to ensure safety and reduce the risk of complication (i.e., bed malfunction, entrapment) for 3 of 3 residents (R122, R45, R222) reviewed who used side rails on their bed. However, the lack of a program had potential to affect all 75 residents residing at either campus. Findings include: R122's admission Minimum Data Set (MDS), dated [DATE], identified R122 had intact cognition and demonstrated no delusional thinking during the review period. Further, the MDS included a section labeled, Section P - Restraints, which marked R122 as not using a bed rail with dictation, 0 = Not Used. On 5/19/25 at 2:51 p.m., R122 was observed lying in bed while in her room. R122's bed had bilateral, chrome-colored metallic 1/2 side rails on both sides of the bed which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. R122 stated she admitted to the care center the week prior from the hospital campus due to needing a ceiling lift for transfers. R122 stated staff had come into her room after she admitted and made me sign something about using the side rails, however, had never asked her about wanting them or not; nor any alternative devices (i.e., smaller grab bar) prior to installing them. R122 stated, rather, staff just showed up with them in the room and said 'can we install these?' to which R122 responded, Sure. R122 stated she used the rails to help with bed mobility, and she denied concerns or injury from these, thus far. R45's significant change in status MDS, dated [DATE], identified R45 had intact cognition and was independent with transfers and bed mobility. The MDS section labeled, Section P - Restraints, marked R45 as not using a bed rail with dictation, 0 = not used. On 5/19/25 at 3:35 p.m., R45 was observed in his room. R45 stated he had bed rails attached to his bed since he moved into the facility last September (2024) and, upon observation, his bed had bilateral, chrome-colored metallic 1/2 side rails which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. R222's admission Minimum Data Set (MDS) dated [DATE] indicated resident had moderate cognitive impairment with no behaviors, and being independent with repositioning side to side, needing moderate assist with changing to and from lying to sitting, and dependent on staff for standing and transfers. The MDS also indicated R222 had no bedrails or alarms. On 5/19/25 at 4:10 p.m., R222's bed was observed which had bilateral, chrome one-half upper side rails attached to the frame of the bed at one attachment point below. The grab bar was loose when touched. (continued on next page)

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F 0909 Level of Harm - Potential for minimal harm Residents Affected - Many	On 5/20/25 at 10:38 a.m., nursing assistant (NA)-A was interviewed, and verified R122 along with many other residents used bilateral side rails. NA-A stated the rails were more kept with the bed, not with the person from their understanding of them. NA-A stated they had never seen other devices, such as a trapeze or smaller grab bar, used on resident' beds and, again, reiterated it was almost always just the bilateral side rails used on resident' beds. SEE F700 FOR ADDITIONAL INFORMATION ON SIDE RAIL USE When interviewed on 5/20/25 at 3:32 p.m., the director of nursing (DON) stated the campus had multiple types of resident beds and they were unsure what, if any, routine review or maintenance program was being done for them. DON stated if a side rail was found to be loose, then staff could complete a work-order for maintenance to address it. On 5/20/25 at 3:45 p.m., the facilities manager (FMR) was interviewed, and he explained the campus used two types of resident' beds adding there had been discussion on getting some of the more dated beds to be phased out in the coming years. FMR explained when a resident discharges the campus, they receive a work-order to remove the side rails from the bed and then, often, get another work-order when a new resident comes in to re-attach the side rails. FMR stated they just assume the nursing department has completed their review of the bed or siderail to ensure safety. FMR stated there was no ongoing, routine maintenance program completed for the beds to ensure safety, either with or without the side rail(s) attached, adding aloud, No, no. FMR stated they had talked about implementing a preventative maintenance program for the beds in the past, however, had never pursued it. FMR stated the floor staff should be checking the beds to ensure safety adding such was a responsibility of them [floor staff]. Further, FMR stated they were unsure if the side rails were made by the bed manufacturer and would look into that adding aloud, That's a great question. On 5/21/25 at 10:33 a.m., a follow-up interview was held with FMR, who explained checking the bed frame and mattress for fitment (i.e., including to reduce the risk of mattress shift and entrapment with the side rail) was all on the [direct] staff. FMR stated they would occasionally have work-order come through to adjust a mattress but not often. FMR stated they had located the user's manual for the bed type(s) which directed annual maintenance should be completed, however, this was not being done. FMR stated they would start a routine maintenance program for the beds to ensure safety adding aloud, That's something we're going to have to go forward with. FMR stated there was no specific user's manual able to be located for the side rails and reiterated issues with safety or maintenance would just be addressed as discovered. A facility' provided Excel document, undated, was provided which was labeled, Work Orders Excel Spreadsheet. This identified all recently completed maintenance items done at either campus. This recorded one issue with a bed control not working, multiple examples of a bed-extender being needed/attached, and one entry which recorded, Other - has old bed, needs brown siderails attached. The provided document lacked any evidence of ongoing preventative screening or maintenance review to ensure resident' bed safety. On 5/21/25 at 10:46 a.m., a follow-up interview with the DON was held. DON stated there was no set schedule or routine for nursing staff to inspect the resident beds to his knowledge. DON stated beds should likely be inspected on a routine basis though to promote safety and reduce the risk of falls and entrapment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gundersen St Elizabeth's Care Center	1200 Fifth Grant Boulevard West Wabasha, MN 55981

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 0909 Level of Harm - Potential for minimal harm Residents Affected - Many	On 5/21/25 at 1:14 p.m. the environmental services director (ESD) was interviewed. ESD explained their staff help with a monthly bed wash on every room and complete the terminal cleaning when a resident discharges. ESD explained they inspect the mattress at that time to ensure it's intact and clean, however, this was not tracked or documented. ESD verified they were not checking for preventative maintenance on the beds or areas where potential entrapment could occur adding if a rail was loose, then a work-order would be completed and the maintenance department would address such. ESD provided a document labeled, Bed Wash, which had each unit listed on a separate page along with initials of staff who completed it. However, the document lacked instructions or directions on what specific items were performed during these monthly washes. A facility' policy on bed maintenance was requested, however, none was received.