STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Williams Living Center	212 West Soo Street, Box 30 Parkers Prairie, MN 56361

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 35569 Based on observation, interview and document review the facility failed to ensure proper assessment of bed rails for 1 of 4 residents (R1) reviewed for siderails. Staff implemented a new mattress on a bed with side rails attached, resulting in R1's head becoming trapped between the mattress and the side rail of the bed. The immediate jeopardy (IJ) began on 4/10/25, at approximately 12:00 a.m., when facility staff replaced the mattress on R1's bed without checking the entrapment zones between the mattress and the side rail resulting in R1's head becoming trapped between the mattress and the siderail. The IJ was identified on 4/17/25, the administrator was notified of the IJ on 4/17/25, at 4:10 p.m. The immediate jeopardy was removed on 4/11/25, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. Findings include: R1's Admission Record indicated he admitted to the facility on [DATE], with diagnosis that included wheezing, pneumonia, sleep apnea and weakness. R1's Safe Patient Handling assessment dated [DATE], identified the use of double half side rails. Initial Siderail/Entrapment assessment dated [DATE], identified the use of side rails for mobility and indicated R1 was able to demonstrate ability to grab side rail and assist in turning and repositioning. The assessment identified the seven potential entrapment zones and was signed as assessed by maintenance staff. R1's Functional Abilities assessment dated [DATE], indicted he required partial to moderate assistance to roll left and right. R1's care plan dated 4/10/25, identified physical limitations in bed mobility related to decreased strength and impaired mobility. The care plan indicated R1 required extensive assistance from one staff for bed mobility. (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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Fall Note dated 4/10/25, indicated R1 was found lying on his right side next to his bed. R1's head was between the mattress and the siderail facing downward with his continuous positive airway pressure (CPAP) machine on. R1's right hip was resting on the frame of the bed side table with his left knee on the floor. R1 sustained a skin tear on his right elbow and a skin tear on his left elbow and complained of right hip pain. R1's head was removed from between the mattress and the side rail. Staff was unable to assess hip/leg pain due to pain which R1 stated was different from back pain. On 4/16/25 at 11:14 a.m., the bed and mattress involved in the incident were observed with the administrator and maintenance staff (MS)-A. The mattress was an alternating pressure mattress with individual air chambers (baffles) which slid into individual sleeves to hold them in place. At least three of the baffles were not inside the sleeves. The administrator felt the mattress was faulty due to the baffles not being inserted into the sleeves. The administrator stated the facility had made the decision to discontinue using that brand of air mattress. The bed had half side rails attached on both sides of the frame. The observation was conducted in a separate area of the facility as the bed had been removed from R1's room following the incident. During interview on 4/16/25, at 4:14 p.m., R1 said he did not remember what happened and said, I think I got hung up in that bed. R1 said he could not get out of the bed, his legs were tied up, and he remembered his head being stuck between the side rail, and he could not get himself loose. R1 also could not get his CPAP loose from his face. R1 recalled being panicky. During interview on 4/17/25, at 6:34 a.m., registered nurse (RN)-A stated when she arrived for her shift on 4/9/25, two staff from the p.m. shift brought a pump and mattress to the unit and said R1's air mattress had not been holding air. At midnight, staff got R1 up to use the bathroom and RN-A and an unidentified nursing assistant (NA) swapped out the mattress on R1's bed. Around 4:00 a.m. RN-A said she went to give a medication to another resident and said when she returned to the medication cart, she heard a grunt or groan. RN-A walked down the hall and heard the noise again and when she entered R1's room she found him laying with his head between the air mattress and the side rail with his CPAP still on his head. RN- A said she called for help and while waiting tried to get R1's head loose but was initially unable to, it was tight, I could not move it. RN-A said she was going to remove the CPAP but noticed it had been pushed up away from his mouth so she hooked it back up so he could get air. RN-A said she had pushed and pulled and all of the sudden R1's head came loose. R1's leg had been resting on the tray table stand and he complained of pain. During a subsequent observation and interview on 4/17/25, at 10:25 a.m., MS-A performed a bed rail gap test using a bed system measurement device, which identified if the bed rail and mattress are at risk for entrapment, on the bed involved during the incident. The test did not pass at the head of the bed. MS-A said bed rails and entrapment zones were assessed upon implementation and quarterly by the maintenance department. The entrapment zones were not assessed when the mattress was swapped out 4/10/25. Facility policy Proper Use of Bed Rails dated 4/10/25, indicated if bed rails are used, the facility ensures correct installation, use, and maintenance of rails. Side rails will not be used with air mattresses due to the risk of entrapment. The facility will ensure the correct installation of bed rails to include ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a residents head or body. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The past noncompliance immediate jeopardy began on 4/10/25/25. The immediate jeopardy was removed 4/11/25, and the deficient practice corrected after the facility implemented a systemic plan that included the following actions: - Updated policy to include side rails will not be used with air mattresses - Licensed nurses were educated on the side rail policy, Side Rail Assessment, Bed Rail/Mattress Safety Assessment including how to measure for gaps that may cause entrapment. - Education was verified through interview and document review.