STATE LICENSING COMPLIANCE REPORT

Report #: HL282048402C

Date Concluded: December 17, 2024

Name, Address, and County of Facility Investigated:
Beacon Home of Wedgewood
3610 Mount Vernon Court
Woodbury, MN 55129
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G (for ALL). The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28204	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HOME OF WEDGEWOOD	3610 MOUNT VERNON COURT WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL282048402C On November 7, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 25 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL282048402C tag identification 0450 and 2350.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements	0 450		

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0 450	Continued From page 1 All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to utilize person-centered planning and service delivery process for one of two (R2) residents reviewed. R2's choices and preferences were not honored when the licensee removed R2's bed rails without R2's consent. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee with a diagnosis of quadriplegia.	0 450		

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0 450	Continued From page 2 R2's vulnerability assessment abuse prevention plan dated June 19, 2024, indicated R2 utilized bed rails while in bed. R2's service delivery records dated July 2024, indicated staff completed safety checks on R2's bed rails once on the dayshift, evening shift, and nightshift. R2's care plan dated July 1, 2024, indicted R2's bed rails were checked for proper working order, daily by staff on every shift. R2's care plan included staff assistance with cough assist by utilization of a medical device as needed, (PRN). R2's annual nursing assessment dated July 2, 2024, indicated the resident was oriented to person, place and time. R2's assessment included the use of a motorized wheelchair and bed rails. The assessment indicated R2 had hand tremors/spasms and R2 did not require fall safety checks. On July 10, 2024, the licensee sent a letter to families, guardians and case managers of resident's of the facility which indicated that effective immediately, the licensee would no longer allow bedrails on any resident's bed. R2's medical records dated July 10, 2024 at 10:03 p.m., indicated a note to R2's medical provider from R2's family member (FM)-I that specified FM-I received notification that bedrails would no longer be allowed at the licensee. This note indicated in the past R2 needed upper and lower bedrails to prevent R2 from falling on the floor but R2's spasms were not as bad as they previously had been. This note also indicated the FM-I requested the bed be in the low position if R2 falls out of bed but had concern if staff placed	0 450		

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0 450	Continued From page 3 pillow on the floor next to the bed and R2 fell out onto the pillows he would suffocate. FM-I also explained that when R2 received his chest vest in the morning, it was not unusual for him to begin to lean to the side when sitting in an upright position and is alone when receiving the chest vest treatments. FM-I indicated there was a greater risk of harm for R2 without the bed rail. FM-I indicated understanding the safety concern but informed that R2's sense of security is also important. R2's progress notes dated July 11, 2024, at 5:01 p.m., by the licensed assisted living director, (LALD)-A, indicated new policy to remove all bedrails was being implemented for the current residents. R2 who was noted to have two bilateral bedrails on his bed, was resistant to have the bedrails removed. LALD-A and a licensee registered nurse, explained to R2 the risks of having the bedrails and options to make R2's bed safer without the bedrails. R2 requested assistance for staff to call a resident advocate. Current bedrails show a risk versus benefit due to R2's independence and a risk for potential entanglement due to a cognitive decline. Both R2 and R2's guardian were notified of the new policy. R2's bed rails were removed from R2's bed despite R2's choice to utlilize the bed rails. R2's progress note dated July 11, 2024 at 5:01 p.m. included that the facility implemented a new policy to remove all bed rails from current residing residents. Resident was noted to have bilateral side rails on his bed. Resident very resistant to have rails removed. RN and writer explained the high risk of bed rails and we discussed ways to make his bed safer without the rails.Resident asked for assistance to call ombudsman. Writer assisted him with the call. Resident asked for	0 450		

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0 450	Continued From page 4 writer to stay in room when call was placed. Resident requires full assistance with lift in and out of bed which is currently care planned. Current bed rails show a risk versus benefit due to resident independence and risk for potential entanglement due to cognitive decline. Resident and Guardian were notifed of new policy. Assessment completed and care plan revised to reflect changes in bed rails. On July 12, 2024, at 8:33 a.m., R2's medical provider sent an inquiry to the licensee's staff requesting more details as to why R2's bed rails were no longer allowed and indicated they were concerned for R2's safety and wanted to know if the licensee provided a fall mat for R2. On July 12, 2024, at 12:20 p.m. registered nurse, (RN)-B informed R2's provider that foam was placed under R2's sheets to better identify the mattress and if R2 was too close to the edge, R2 could use his call light for assistance. RN-B's note additionally indicated R2 wanted the bedrails for fear of falling out of bed, but they were considered a restraint when used for that purpose. RN-B indicated a fall mat could be placed on the floor. R2's progress notes dated July 17, 2024, at 10:14 a.m., by a registered nurse, indicated R2's service agreement was updated for bed rail removal. R2's progress notes dated August 9, 2024, at 12:56 p.m., by LALD-A, indicated a meeting was held with RN-B, licensee administrative staff, and R2's resident advocate, (ADV)-J. ADV-J informed group R2 wanted his bedrails re-installed. LALD-A and RN-B expressed concern over reinstalling R2's bedrails for safety reasons. ADV-J informed	0 450		

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0 450	Continued From page 5 them R2 knew the risks of the dangers of the bedrails and continued to want them on his bed. LALD-A and RN-B recommended R2 use a larger bed, however, R2 was resistant due to the cost. LALD-A and RN-B informed they would check into opportunities for R2's insurance to cover the cost of larger bed and also reach out to R2's family. R2's progress notes dated August 12, 2024, at 12:45 p.m., by LALD-A, who spoke with a family member (FM)-I, about getting R2 a larger bed. FM-I is resistant to getting R2 a larger bed due to cost. FM-I would reach out to R2's provider about getting R2 a fall mat and seek further options. FM-I understood the risks of bed rails and would work with the licensee to find a solution. R2's progress notes dated August 14, 2024, at 4:28 p.m., completed by LALD-A, who spoke with ADV-J regarding R2's continued request to reinstall R2's bedrails for fear that he (R2), might fall out of his bed. LALD-A expressed concerns over R2's lack of mobility and the dangers of reinstalling the bedrails. ADV-J informed LALD-A, R2 objected the bedrail removal and requested to have them regardless of the risks and safety. At that time the bedrails continue to be removed as policy indicated "In the event it is determined by licensee staff that the bedrails pose a greater risk for injury than benefit for the resident's use. Resident agrees do not apply to the device." Occupational therapy, (OT), was ordered. R2's progress notes dated August 18, 2024, by licensed practical nurse, (LPN)-D, indicated staff completed R2's "rock and roll" on August 17, 204, at approximately 11:00 p.m., and R2 fell out of his bed. R2 hit his head on the way down and	0 450		

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0 450	Continued From page 6 sustained an abrasion on his head. 911 was called due to possible head injury. Paramedics arrived and assessed R2 and did not believe R2 injured his head. R2 did not wish to be sent to the hospital for further evaluation. A licensee's incident report dated August 17, 2024, at 11:00 p.m., indicated R2 had a witnessed fall after facility completed R2's "back taps" and when about to place a pillow under R2's head, noticed R2's legs were twisted. When the staff had untwisted R2's legs, R2's body jerked. Paramedics arrived and completed a physical and neurological assessment. R2's progress notes dated August 21, 2024, at 12:21 p.m., indicated R2 did not wish to discuss bedrails with OT due to R2 needing a care conference with the licensee. RN-B explained to OT that R2 is a quadriplegic and would not be using the bedrails for mobility. OT stated that she would not recommend bedrails to keep R2 in bed as that would be a restraint. R2's medical records dated August 29, 2024, at 9:58 p.m., by FM-I to R2's provider inquired if the provider could write an order for bedrails. FM-I's inquiry indicated R2 had bedrails for seven years without one incident, then within six weeks after the bedrails were removed, R2 fell out of bed. R2's medical records dated August 30, 2024, at 10:06 a.m., indicated R2's provider's response to FM-I, that indicated R2's provider asked the licensee if an order for bedrails was written, if R2 could use them, and the licensee informed R2's provider that bedrails were no longer allowed at the licensee. R2's progress notes dated September 3, 2024, at	0 450		

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0 450	Continued From page 7 12:36 p.m., by RN-B indicated OT had seen R2 on August 28, 2024, and OT had been in agreement with R2's nursing assessment for bed rail use that indicated R2 would not need to use bedrails for bed mobility. RN-B indicated that bed rails would only be used to keep R2 in bed and have the potential to strangulate R2 because of R2's inability to move without assistance. R2's OT medical records dated September 6, 2024, indicated bedrails for R2 were not needed functionally and recommended other options for safety. The OT record indicated R2 wanted the bedrails for safety, specifically for fear of falling and was willing to sign a risk acknowledgement and the medical record indicated the OT personnel recommended the bedrail issue be handled with the licensee and R2's provider not a skilled OT personnel. On September 5,2024, at 4:59 p.m. LALD-A sent an inquiry to the MDH about a resident, (R2), who was totally paralyzed and only has movement of his chin. LALD-A and an RN assessed the situation and have determined that a bed rail is a safety risk because R2 is unable to prevent himself from being trapped and entangled in the bed rail. R2 is requesting the bed rails to be used, even though he is not using the bed rails for mobility. On September 10, 2024, at 1:04 p.m., MDH replied to LALD-A and indicated R2 ultimately had the choice to have a bed rail if they want it and every resident has the right to make choices. MDH also indicated that the licensee could not have a blanket policy that indicated bedrails were not allowed, and the licensee does have the responsibility to inform, educate, assess, and review the risk versus benefits, then additionally,	0 450		

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0 450	Continued From page 8 offer services to help mitigate the safety risk is the situation had determined to be unsafe. An example was supplied by MDH of the resident signing a negotiated risk assessment. No changes were made to the licensee's policy following the reciept of the September 10, 2024 email response from MDH and bed rails were not installed on R2's bed, despite R2's request for bed rails. In email correspondance with the LALD-A on November 15, 2024 at 2:47 p.m., LALD-A indicated they discussed the risk versus benefits of the bedrails and lack of benefit with R2, who is his own guardian. A brochure was given to R2 that showed the risk of entanglement. LALD-A's indicated at the time of the discussion, R2 understood the risks and agreed to have the bedrails removed. LALD-A's email indicted a larger bed was recommended for R2 but R2 and his family did not wish to purchase one. LALD-A stated the interventions of purchasing a lower bed, placing the bed towards the wall or a floor mat were all rejected by the resident. LALD-A's indicated the licensee's policy prohibits the use of a bedrail when assessed by a qualified person, offers no benefit and pose an intolerable risk. LALD-A stated R2 signed a resident agreement which prohibited the resident from creating dangers to himself and using bedrails in this circumstance operates only as a restraint and create significant risk given R2's physical condition. LALD-A indicated that the community has a statutory obligation to provide appropriate care and services to R2. Allowing R2 to use a dangerous device on the premises puts the licensee at risk of violating its own obligations under assisted living statute. R2 had the right to furnish his own area, these rights may be limited	0 450		

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0 450	Continued From page 9 by the Assisted Living Contract as in this case. A copy of the Assisted Living Contract signed by R2 was requested but not provided by the licensee. During an interview dated November 13, 2024, at 11:41 a.m., R2's family (FM)-I stated the licensee did not give ample warning of removing R2's bed rail. FM-I recalled R2 having orders for the bed rails. FM-I had been at the licensee while R2 was receiving his chest vest treatment with a mask on his face and sitting up in the middle of the bed. FM-I stated R2 had reported to her times when R2 had to call staff because he was too close to the side of the bed. FM-I stated the licensee recommended she purchase a floor mat; however, FM-I had concerns that if the floor mat is too thick and R2 falls on it he could suffocate. FM-I could not understand as R2 had been using his bed rails for seven years without issues and R2 needs them for his security. R2 had offered all along to have a risk versus benefits signed to have his bedrails back. During an interview dated November 14, 2024, at 9:00 a.m., ADV-J stated R2 reported to her that his bed rails were removed abruptly. ADV-J stated that R2 reported even though his bed is in the low position, his respiratory treatment requires him to be in an upright position without licensee's staff present which is concerning with out his bedrails. R2 reported to ADV-J that he felt safe with his bed rails and requested to have safety checks increased if bed rails were reinstalled to which the licensee responded that R2's service plan would change and there might be a possibility the licensee could not meet R2's needs. R2 reported that he would sign a risk versus benefits to have the bedrails reinstalled.	0 450		

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0 450	Continued From page 10 ADV-J stated she was informed by FM-I that R2's bed was checked for proper functioning and was appropriate and without manufacturing concerns for bed rail installation. ADV-J stated R2 sent her a text from his agency nurse that indicated the agency nurse supported R2 in his decision to have his bedrails. ADV-J recommended to the licensee that R2 had the right to choose and understands the risks of using his bed rails. The facility's Bed Rail Policy dated August 1, 2021 and reviewed on July 10, 2024, indicated that the licensee would not allow bedrails or similar devices which may act as a restraint or entrapment risk for a resident. A nursing assessment and physician's order must be obtained. The following information must be provided prior to bedrail installation: in the event it is determined by the licensee staff that the bedrail poses a greater risk for injury than a benefit for the resident's use, the resident agrees to not apply or use the bedrail. Resident agrees that even if a bedrail is initially determined to be a benefit by the licensee, if the bedrails are determined to pose a greater risk for injury than benefit by the licensee's registered nurse, the bedrails would be immediately removed. The Minnesota Department of Health's, (MDH), Bedrail and Assistive Device Safety and Regulation dated February 17, 2023, indicated if a device is not safe for the resident: Offer alternatives, and discuss and offer interventions to mitigate safety risks. Document your assessment and all interventions discussed, offer or attempted. If you use a negotiated risk agreement or similar, you must: maintain documentation of the offer of alternatives, implement interventions to mitigate safety risks, and conduct ongoing reassessment for the	0 450		

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0 450	Continued From page 11 appropriate use of a bedrail. For Risk versus benefits: consider resident preference and the resident uses the device, have individualized assessment of risks and document education of the resident and their family of the risks. The facility's Resident Bill of Rights date May 12, 2021, indicated under (7) Residents have the right to individual autonomy, initiative, and independence in making life choices. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents and their property were treated with courtesy and respect for one of two residents (R1) when bedrails were removed from R1's bed without his consent. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	02350		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02350	Continued From page 12 The findings include: R1: R1 admitted to the facility with a diagnoses which included quadriplegia. R1's nursing assessment dated June 27, 2024, signed by registered nurse, (RN)-B, indicated R1 utilized bed rails. R1's vulnerability assessment/abuse prevention plan dated June 27, 2024, indicated R1 had a bed rail assessment in place, a bed rail risk agreement in place, safety checks of side rails every shift when in use and used the bed rails for bed mobility. R1's service agreement dated July 1, 2024, completed by licensed practical nurse, (LPN)-D, indicated R1 needed physical assistance to turn and reposition when in bed. Additionally, unlicensed personnel, (ULP), were to check bedrails every shift to assure it is secured to the bed frame, the rail is flush with the mattress and the resident is only using it to get in and out of bed or bed mobility. Report loose or damaged bed rails to the nurse. Licensee to provide monitoring of one-half bedrail for safety. A letter dated July 10, 2024, addressed to families, guardians, and case managers, indicated that effective immediately, the licensee would no longer allow bedrails on any resident's bed. R1's progress notes dated July 17, 2024, indicated R1's service agreement was updated for bed rail removal.	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28204	A. BUILDING: _____ B. WING _____	C 11/07/2024

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02350	Continued From page 13 R1's progress notes dated July 25, 2024, indicated R1 was seen by occupational therapy, (OT), and OT worked with R1 on bed mobility. R1's progress notes dated August 9, 2024, completed by licensed assisted living director, (LALD)-A, indicated the licensee's registered nurse, LALD-A, and R1's resident advocate, (ADV)-J, discussed R1's bed rails. ADV-J stated R1 wanted his bed rails reinstalled. LALD and the RN expressed concern over reinstalling R1's bedrails for the safety of the resident and ADV-J stated R1 knew the risks of the bed rails and continued to wish to have them reinstalled. LALD-A and RN were working with R1's provider and OT to set-up a plan to assist R1 for bed mobility and safety concerns. R1's medical records dated August 22, 2024, indicated R1's provider ordered R1 to have bed rails and that R1 understood the risks involved using the bed rails. R1's individual informed consent for use of bed rail/transfer rail form dated September 12, 2024, signed by R1, indicated R1 reviewed the licensee's information and was aware of the risks associated with the use of a bed rail and chose to utilize a device against medical advice. R1's medical records indicated staff completed daily bed rail checks starting on September 12, 2024 through September 30, 2024. R1's vulnerability assessment/abuse prevention plan dated September 27, 2024, indicated R1 had half bedrails on his bed for repositioning and bowel program assistance. R1's bed rails are only used when staff are in R1's room. Staff monitor placement and security of bedrails daily. a bed	02350		

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	28204	A. BUILDING: _____ B. WING _____	C 11/07/2024

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02350	Continued From page 14 rail assessment in place, a bed rail risk agreement in place, safety checks of side rail every shift when in use in place and used the bed rails for bed mobility. Goals included: R1 would experience improved bed mobility and positioning, remain free from injury and bed rails will remain in proper working order. During an interview on November 7, 2024 at 1:30 p.m., R1 stated he went through a lot with LALD-A in order to get the bedrails back on his bed. R1 stated the LALD-A took his bedrails off his bed that he used to assist in turning and repositioning and bed mobility and it took weeks to get them back on. R1 stated when his bed rails were taken off of his bed, his quality of life decreased because he had to lay in bed longer because it took two staff to turn him without the bed rails. R1 stated he had to have his provider and an OT person visit just to get the bed rails put back on his bed. During an interview on November 14, 2024, at 9:00 a.m., R1's resident advocate (ADV)-J stated R1 informed her that the licensee took his bed rails off without warning and placed them in the licensee's garage. R1 informed ADV-J that the bed rails were for placing his hands on the rails for bed mobility and when removed, he had delays in obtaining staff assistance due to needing two staff for assistance. R1 informed ADV-J that he went through hoops and frustration to get his bedrails back. R1 informed ADV-J that his bed rails were placed back on his bed in October 2024. The facility's Resident Bill of Rights dated May 12, 2021, indicated under Courteous Treatment: Residents have the right to be treated with courtesy and respect and to have their property	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02350	Continued From page 15 treated with respect. Residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. The facility's Resident Bill of Rights dated May 12, 2021, indicated under (7) Residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. The facility's Bed Rail Policy dated August 1, 2021 and reviewed on July 10, 2024, indicated that the licensee would not allow bedrails or similar devices which may act as a restraint or entrapment risk for a resident. A nursing assessment and physician's order must be obtained. The following information must be provided prior to bedrail installation: in the event it is determined by the licensee staff that the bedrail poses a greater risk for injury than a benefit for the resident's use, the resident agrees to not apply or use the bedrail. Resident agrees that even if a bedrail is initially determined to be a benefit by the licensee, if the bedrails are determined to pose a greater risk for injury than benefit by the licensee's registered nurse, the bedrails would be immediately removed. No further information provided. Time period for correction: Seven (7) days	02350		