LONG TERM CARE
COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Issue Alert: Bed Rails

I. Why are Bed Rails a Serious Concern for Nursing Home Residents?

The use of bed rails, also referred to as side rails or safety rails, is associated with an increased risk of preventable harm and death for nursing home residents. According to the federal Centers for Medicare & Medicaid Services (CMS), residents may attempt "to exit through, between, under, over, or around bed rails or . . . crawl over the foot board, which places them at risk of serious injury or death."[1] Such actions can lead to falls or entrapment, which occurs when a resident becomes caught in the bed rail or between the mattress and the bed rail. Sadly, and all too often, resident entrapment leads to death.

Note to Readers:

LTCCC Issue Alerts provide basic information about an issue of concern to nursing home residents.

For further information, please see the Resources and references at the end of the Alert, as well as our website, www.nursinghome411.org.

II. What are the Requirements for Bed Rails?

Every nursing home must adhere to standards of care for bed rails. These standards of care are found in the bed rail and resident bed requirements:

1. **Bed Rails. Nursing homes must try to use an appropriate alternative first. If bed rails are used, nursing homes must assess the resident for associated risks, obtain the resident's informed consent, and ensure proper use and maintenance.**
    - *The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.*
        - *Assess the resident for risk of entrapment from bed rails prior to installation.*
        - *Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.*
        - *Ensure that the bed's dimensions are appropriate for the resident's size and weight.*
        - *Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.*[2]

2. **Resident Beds. Nursing homes must regularly inspect bed frames, mattresses, and bed rails to identify the potential for resident entrapment.**
    - *Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.*[3]

CMS's Interpretative Guidance adds that nursing homes must provide residents or their representatives with the information they need to make an informed decision about the use of bed rails. **Informed consent must be based on information that is presented in a manner that the resident or representative understands, be free from coercion, and include the following information:**

1. *What assessed medical needs would be addressed by the use of the bed rails;*
2. *The resident's benefits from the use of bed rails and the likelihood of these benefits;*
3. *The resident's risks from the use of bed rails and how these risks will be mitigated; and*
4. *Alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate.*[4]

CMS Guidance acknowledges that the use of bed rails poses significant risks to nursing home residents who have "physical limitations or altered mental status, such as dementia or delirium," even after all the requirements have been met. The Guidance emphasizes that **bed rails can increase accidental hazards, act as a barrier to safely getting out of bed, act as physical restraints,**[5] **and result in other negative physical and psychological outcomes.**

A study by the Food & Drug Administration (FDA) found that 803 entrapments were reported between 1985 and 2009. 480 of these entrapments resulted in death. The study notes that "[l]ong-term care facilities reported the majority of the entrapments."

A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, FDA

III. How Dangerous are Bed Rails?

According to a study by the U.S. Consumer Product Safety Commission, 155 people died between 2003 and 2012, and about 36,900 people were injured (2003-2011), due to adult portable bed rail use.[6] The study indicates that 93 percent of fatalities were the result of rail entrapment and seven percent of incidents were the result of falls. The study found that 83 percent of individuals who died because of bed rail use were 60 years old or older. Furthermore, 25.8 percent of the overall deaths occurred in a nursing home or an assisted living facility (**note: there are no federal bed rail standards for assisted living facilities**).[7]

IV. Citations for Bed Rail and Resident Bed Deficiencies.

Please Note: LTCCC Issue Alerts are typically accompanied by information posted on our website on nursing homes that have been cited for a deficiency related to the topic covered.

However, though nursing homes have ***always*** been required to ensure resident safety and avoid the unnecessary use of bed rails and other restraints, a specific citation tag for bed rails did not exist until November 28, 2017. Thus, when this Alert was written (April 2018) few bed rail or resident bed deficiencies have been cited.

Previously, bed rail and resident bed deficiencies were cited under the requirements for accidents and resident rooms. However, both of these requirements encompassed additional standards beyond the bed rail and resident bed requirements. Thus, we will not be posting bed rail deficiencies on our website at the time. However, we strongly urge residents, families, and those who work with them to be aware of and vigilant about the use of bed rails and other restraining devices.

V. Case Study of a Resident Who was Placed in a Highly Risky Environment Due to Improper Bed Rail Use

When a state surveyor identifies substandard care, those findings are described in what is called a Statement of Deficiencies (SoD). All nursing home SoDs are published on Nursing Home Compare. An August 2016 inspection of Premier Genesee Center for Nursing and Rehab in Batavia, New York, illustrates one such instance where surveyors cited a nursing home for substandard care due to deficient bed rail practices.[8]

When state surveyors inspected the nursing home, they found that the facility was deficient in "ensur[ing] that the resident area remained as free of accident hazards as possible."

Surveyors observed a resident attempting to place a telephone receiver back onto its base. Surveyors then saw a bed rail slide six inches away from the resident's bed after the resident leaned against the rail. According to the director of maintenance, the bed rails were made of conduit and "were not intended to be attached to the bedframe." The director of maintenance then told surveyors that he actually designed and made the rails himself. The director later added that, although the facility occasionally zip tied the rails to resident beds, the rails were "not designed to be affixed to the bedframe. If someone falls against the rails, they will not hold them."

My mother's death certificate states, "Deceased rolled out of bed compressing neck on portable railing." …She died of asphyxia…. Had I never pursued the matter further, I would have assumed that my mother was the only person to ever have died from asphyxiation on a bed rail.

An Advocate's Story: A Mother's Death and a Warning About Bed Rails—The National Consumer Voice for Quality Long-Term Care

The director of therapy told surveyors that bed rails were made by the facility and that the therapy unit would assess for use. She added that there was a previous incident where the rail similarly slid away from a resident's bed but that she "did not remember if this incident resulted in an injury or not." The director of therapy noted that it is important to know what the maximum or minimum weight requirements for bed rails are and that she would usually look at the paperwork that came with the rails; she provided that she "cannot do that that with these rails…."

Surveyors discovered that 34 resident bedframes were using the facility-made bed rails. Surveyors determined that "the facility was manufacturing their own bed assist rails without knowledge of safe operating parameters, including, but not limited to, minimum and maximum weight limits for functionality and failure parameters."

Despite these findings, surveyors cited the facility at the "D" scope and severity level, meaning that they found "no harm" or "immediate jeopardy" caused by this violation.

VI. A Note on Nursing Home Oversight & Accountability

The accurate identification of substandard nursing home care is a longstanding issue of public concern. Too often, even when resident abuse or neglect are cited, the problems are not identified by surveyors as having caused harm to the nursing home's residents. A report by the Government Accountability Office (GAO) found that a "substantial proportion of federal comparative surveys identify missed deficiencies at the potential for more than minimal harm level or above."[9] Recent studies by LTCCC also indicated that states only identify resident harm about 5% of the time that they cite a facility for substandard care, abuse, or neglect.[10] It is important to note that, in the absence of a finding of harm, facilities rarely, if ever, face a penalty for the substandard care or services provided.

VII. Alternatives to Bed Rails

A resident's risk of falling off his or her bed is a serious concern and should be addressed by nursing home staff. However, there is often a more appropriate alternative to bed rail use for residents at risk of falls or entrapment. **The Food & Drug Administration (FDA) provides that alternatives include "roll guards, foam bumpers, lowering the bed and using concave mattresses that can help reduce rolling off the bed."[11]**

VIII. References for More Information & Help

- **Fact Sheets.** The Learning Center on LTCCC's website, www.nursinghome411.org, contains easy-to-use fact sheets on many of the nursing home standards of care most relevant to residents, including one on bed rails.
- **Resources.** The Consumer Voice has a dedicated page on its website, www.theconsumervoice.org, with information and resources on the dangers bed rails pose to elderly individuals: http://theconsumervoice.org/issues/other-issues-and-resources/dangers-of-bed-rails.
- **Federal Requirements & Guidance.**
  - **Bedrails**. LTCCC has posted the federal Guidance related to the use of bedrails on our website at http://nursinghome411.org/cms-guidance-nursing-home-bed-rails/.
  - **General**. The CMS State Operations Manual provides, in an appendix, the Interpretative Guidance, which specifies expectations for nursing home services and state enforcement. See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

- **News Report.** A resident of a Minnesota nursing home died of suffocation after her head became trapped between her mattress and the bed's side rail. A report by the state's health department found that the facility failed to have any policies or procedures in relation to mattress size and rail spacing. Her husband reported that his wife's suffocation was not the only problem that they had at the facility. See http://www.startribune.com/state-death-report-neglect-led-to-nursing-home-resident-s-suffocation/469549113/.
- **News Report.** The father of a Pennsylvania state representative died after his head became trapped between his mattress and the bed's side rails. According to the Allegany County Medical Examiner's Office, the resident's neck was "compressed." See https://www.wpxi.com/news/top-stories/state-lawmakers-father-died-after-head-caught-in-bed-rails-at-nursing-home/645222437.

Please share your thoughts with us on Twitter using **#HarmMatters**. For more information on "no harm" deficiencies, please see our monthly newsletter:
Elder Justice: What "No Harm" Really Means for Residents.
Email **info@ltccc.org** to sign up for our alerts & newsletters and visit **www.nursinghome411.org** for additional resources & information on nursing home quality and accountability.

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[1] State Operations Manual, Appendix PP, CMS, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf (providing guidance for 42 C.F.R §§ 483.10(e)(1), 483.12(a)(2)—Respect and Dignity).
[2] *Id.* at § 483.25(n)(1)-(4). This is the regulatory cite for the bed rails requirement.
[3] *Id.* at § 483.90(d)(3). This is the regulatory cite for the resident bed requirement.
[4] *See id.* at § 483.25(n)(1)-(4) (providing guidance to the requirement).
[5] *See id*. at § 483.12(a)(2) (stating that facilities must ensure residents are free from restraints "imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints").
[6] *See Adult Portable Bed Rail-Related Deaths, Injuries, and Potential Injuries: January 2003 to September 2012*, U.S. Consumer Product Safety Commission, available at https://www.cpsc.gov/s3fs-public/adultbedrail.pdf noting that the number of injuries treated in U.S. hospitals is based on estimates by the National Electronic Injury Surveillance System).
[7] Twenty five of the deaths occurred in nursing homes and 15 deaths occurred in assisted living facilities. *Id.* The majority of deaths—94—occurred at home. *Id.*
[8] *Statement of Deficiencies for Premier Genesee Center for Nursing and Rehab*, CMS (Aug. 22, 2016), available at https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=335423&SURVEYDATE=08/22/2016&INSPTYPE=STD. Please note that this inspection occurred before the new survey system went into effect and prior to the revised nursing home Requirements of Participation.
[9] *Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, GAO (May 2008), https://www.gao.gov/assets/280/275154.pdf.
[10] Richard J. Mollot & Rediet Demissie, *The Identification of Resident Harm in Nursing Home Deficiencies: Observation & Insights*, LTCCC (2017), http://nursinghome411.org/identification-of-resident-harm-in-nursing-home-citations/.
[11] *Recommendations for Consumers and Caregivers about Bed Rails*, FDA, https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362843.htm (last visited March 8, 2018).