Dear Residents, Family Members and Staff of Lutheran Care Center:

In alignment with our commitment to safe, dignified, and person-centered care, we propose a targeted shift in our use of bed siderails within the facility. The clinical team—guided by best practices, regulatory standards, and resident-specific assessments—supports the discontinuation of routine siderail deployment unless clearly indicated for therapeutic benefit and implemented with minimal risk. This approach reflects our ongoing dedication to reducing harm, preserving autonomy, and enhancing overall quality of life for those entrusted to our care.

Our proposed policy shift is grounded in a growing body of clinical evidence, regulatory guidance, and person-centered care principles. While side rails have historically been seen as safety tools, recent studies and national standards suggest that indiscriminate use may unintentionally increase risk rather than prevent harm, as summarized in the following bullet points.

- **Safety Concerns**: Research shows siderails do *not* reliably prevent falls—and in some cases, especially among residents with cognitive impairment, they may provoke attempts to climb or escape, leading to more severe injuries.
- **Entrapment Risk**: The FDA has identified multiple zones where entrapment may occur between bed rails and mattresses. These can result in serious harm, including asphyxiation.
- **Psychological Impact**: For many residents, particularly those with dementia, siderails can heighten confusion, agitation, or feelings of imprisonment, undermining emotional well-being and quality of life.
- **Regulatory Alignment**:
    - CMS F700 Guidance requires facilities to conduct individualized assessments, obtain informed consent, and prioritize safer alternatives.
    - The New York State Department of Health has recently issued advisories highlighting increased citations related to inappropriate side rail use, emphasizing the need for thoughtful policy reassessment.

In short, this policy aligns with our goals of harm reduction, compliance, and dignity-focused care. Siderails will remain available for clinically justified cases, always paired with rigorous risk evaluation and informed decision-making.

Our recommendation to reduce the use of bed siderails is supported not only by national clinical standards but also by recent advisories and incident trends within New York State. Between 1985 and 2009, the FDA received over 800 reports of residents caught, trapped, or strangled by bed rails—480 of which resulted in death. Most fatalities occurred when residents became entrapped between the rail and mattress, leading to asphyxiation. These risks are not theoretical; they have been reflected in real-world outcomes across New York nursing homes.

In June 2025, the New York State Department of Health issued a statewide letter to Administrators highlighting increased citations related to siderail-related injuries and entrapment. The letter specifically urges facilities to re-examine bed systems and components, citing wear and tear, improper installation, and inadequate assessments as contributing factors to recent negative outcomes.

Common issues that may occur resulting from broad use of side rails may include documentation gaps, inconsistent consent procedures, mechanical concerns, and Department of Health Survey citation risks.

These examples illustrate both the potential clinical risks and the regulatory vulnerability posed by routine siderail use. By adopting a policy that restricts side rails to cases with clear, well-documented therapeutic value—paired with robust assessments and transparent communication, we not only enhance resident safety but also demonstrate proactive leadership in quality improvement and regulatory alignment.

To ensure a safe and thoughtful transition away from routine siderail use, our facility will adopt a phased implementation strategy grounded in clinical rigor and stakeholder engagement. Beginning with finalizing the revised policy, we will communicate expectations clearly to staff and stakeholders through departmental meetings and written updates. All current residents using side rails will undergo standardized reassessment to determine clinical justification, ensuring that use is reserved for therapeutic need and minimal risk. Concurrently, staff will receive in-depth

training on safe alternatives, including low beds, positional support equipment, and scripting techniques for family conversations—to reinforce informed, empathetic care. Recognizing the importance of transparency, we will distribute an FAQ outlining the rationale and safety benefits of the new approach, with myself and others available to support discussions. Upon policy activation, we will initiate audit procedures to monitor compliance and fall trends, report quarterly outcomes to the QAPI Committee, and remain responsive to stakeholder feedback. This strategy reflects our deep commitment to regulatory alignment, harm reduction, and the dignity-centered care our residents deserve.

As always, I make myself available to you to further address any questions or concerns you have related to this or any other matter.

Sincerely,

Albert L. Riddle, MD, CMD, HMDC

Medical Director

Lutheran Care Center