Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2018;	2017_539120_0059 (A4)	005504-17	Follow up

Licensee/Titulaire de permis

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

Long-Term Care Home/Foyer de soins de longue durée

Albright Gardens
5050 Hillside Drive Beamsville ON L0R 1B2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendments were made to public order and report to remove personal health information.

Issued on this 28 day of February 2018 (A4)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 1 & 2, 2017

An inspection (2017-555506-0011) was previously conducted January 4-6, 2017, at which time non-compliance was identified related to the home's bed safety program. Subsequently, a Compliance Order was issued with a compliance due date of July 31, 2017. For this follow-up inspection, two out of the three conditions laid out in the Compliance Order have not been fully met.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Resident Care, Chief Nursing Officer, Director of Maintenance and Properties, RAI-MDS Coordinator, registered and non-registered staff.

During the course of the inspection, the inspector toured several floors, observed resident bed systems, reviewed the home's bed safety policies and procedures and associated resident assessment forms, resident clinical records, bed entrapment audit results and staff education materials.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

(A2)
1. The licensee did not ensure that where bed rails were used, that (#1) the resident was assessed in accordance with prevailing practices to minimize risk to the resident, and (#2) the resident's bed system was evaluated in accordance with prevailing practices to minimize risk to the resident.

A Compliance Order (CO) was previously issued on June 2, 2017, for an inspection conducted in January 2017, related to the licensee's bed safety program. Three requirements were to be implemented, one was complied with, the second requirement included that all residents that used bed rails be assessed in accordance with a specified prevailing practice and the third requirement included staff education. During this follow up inspection, it was determined that residents were not adequately assessed and that bed systems were not evaluated in accordance with prevailing practices. Staff education for registered staff was completed, but was limited for personal support workers (PSWs). Action on the part of the licensee is required.

(#1) Resident Assessments

According to a prevailing practice titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be clinically assessed by an interdisciplinary team, over a period of time, while in bed, by answering a series of

questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use. Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, entrapment, bruising or other skin injuries and entanglement. As such, bed rails and mattresses must be maintained in a safe condition (as per manufacturer's directions), pass all zones of entrapment (specific areas that are measured around the bed rail and mattress and the bed rail itself), and the resident must be clinically assessed to determine if they are able to understand and safely use the bed rails to minimize any inherent risks to themselves. For therapeutic surfaces, additional considerations must be included if bed rails will be used as the surfaces do not all have a firm perimeter edge and can be very compressible in nature. These types of surfaces cannot be measured for entrapment zones and as such, the risks are inherently greater for residents who are placed on them. Residents may benefit from the surface, but those at risk of entrapment due to bed rail application must be assessed with greater restrictions and employ the prevailing guidelines titled "A Guide to Modifying Bed Systems Using Accessories to Reduce the Risk of Entrapment, June 2006" (developed by the US Food and Drug Administration and adopted by Health Canada).

A. Resident #100 and three additional identified residents, all of whom were confirmed by the RAI-MDS Coordinator and registered staff to have been provided with a therapeutic surface and who used one or more bed rails were at risk of entrapment. The surfaces were all soft and compressible and therefore did not pass entrapment testing. No accessories were included in the mitigation of these entrapment risks.

Resident #100 was admitted to the home in 2017, and placed on a standard foam-based mattress which passed entrapment testing in 2016. They were assessed two months later, as requiring one bed rail. According to the RN who completed the "Bed Rail Use Assessment Form", the resident requested the use of the bed rail (rather their Substitute Decision Maker - SDM) for repositioning and was identified to have only one risk factor for injury when bed rails were applied. The alternatives that were listed on the form were not selected and no documentation as to why the bed rail was not trialled. According to progress notes made by an RN, the SDM insisted that that they be applied despite the potential risks explained to them. As part of the assessment process, a "Night Bed Rail Observation" form was to have been completed by night staff for three nights, which required staff to

observe the resident for risks while bed rails were applied. However the forms located in the resident's chart for each night were not completed.

According to the prevailing practices, residents are to be re-assessed when a change in their condition occurs and/or when their bed system is changed. In 2017, both the resident's condition and their bed system changed. The resident fell and injured themselves and was transported to hospital. They were re-admitted to the home, and although not documented, several staff members who knew the resident recalled that the therapeutic surface was provided shortly after arriving from hospital. According to the resident's clinical record after being re-admitted to the home from hospital, registered staff documented that the resident had behaviours and symptoms, which increased their risk of a bed related injury and was found on the floor several times. For three nights, the "Night Bed Rail Observation" forms, identified that the resident slept in a position that placed the resident at potential risk of a bed related injury. A "Bed Rail Use Assessment" form could not be located in the resident's chart. The plan of care was not revised to include the intervention of the therapeutic surface, the reason for it's implementation or date implemented. No progress notes were made regarding the use of the therapeutic surface. There was no information in the resident's clinical record regarding their ability to continue to use bed rails safely while on a different surface, one that reacted to the residents weight and movements very differently than that of a standard foam mattress. The risk over the benefits of continuing to use bed rails was not identified, no alternatives were listed as trialled before applying the bed rails while on a therapeutic surface and no accessories were listed as being necessary to mitigate any entrapment zones.

During the inspection, the therapeutic surface (which was very soft and compressible) was observed on the resident's bed frame whereby one bed rail was elevated or applied (resident was not in bed). According to the resident's most current written plan of care, two bed rails were to be applied when the resident was in bed for a specified reason, but not for bed mobility or transfers. No other information was included, such as the need for accessories necessary to mitigate identified risk factors such as bed rail injury or possible entrapment.

Discussion held with the nursing management team revealed that they were unaware of when the therapeutic surface was applied and were not aware that the written plan of care did not include the details of the intervention. The resident was re-assessed during the inspection, and the DOC reported that the surface would be removed by end of day as it was not required. However, no indication was made if

the bed was re-measured after the foam mattress was re-applied.

B. The clinical guidance document emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The process was also repeated in the licensee's bed safety and use of restraints policies and procedures. The licensee's "Bed Rail Use Assessment" Form included an "alternatives" section for completion by the RN, however no provisions were made on the form itself to document the date(s) trialled and the outcome, or space to include any other note related to why they were not trialled. The options on the form included several interventions such as low bed, scheduled toileting, increased monitoring and restorative care, but no actual bed rail alternatives. The interventions listed are options that can be implemented with or without bed rails in place. No bed rail alternatives were listed such as perimeter reminders, positioning rolls, roll guards, raised or lipped mattresses, or soft rails/bolsters. When discussed with the Director of Nursing and Chief Nursing Officer, about availability in the home of these alternatives, positioning pillows or body pillow, bolsters and raised perimeter mattresses were available, but were not included as an alternative to the use of bed rails, but for other purposes. Out of the seven residents selected for review, none included any information on their "Bed Rail Use Assessment" form about the use of any alternatives or the interventions (if selected), or any documentation that described why they were not implemented if not appropriate.

C. Residents #100, 101, 102, 103 and 104 were not in bed during the inspection, but each of their bed systems had one or more bed rails elevated or "applied". According to the written plan of care for each resident, bed rails were identified to be a personal assistance services device (PASD) and were to be applied while the resident was in bed. During a tour of the home, a total of 40 additional unoccupied bed systems were observed to have one or more bed rails elevated or applied and most were covered by the bed spread. According to a personal support worker (PSW), the bed rails were supposed to be left "down" when the resident was assisted out of bed in the morning and that out of habit, some staff had left them "elevated" all day. It was determined through discussions with various staff, that some beds were made by non-nursing staff and they may not have been aware of

the home's policy on the application of PASDs.

According to a notice titled "Bed Rail Policy - Direction to PSW", which was posted on a bulletin board on May 12, 2017, within each home area, direction was given to PSWs that included that "bed rails only be applied if assessment warrants their use and they have been included in a care plan". The home's policy titled "Use of Personal Assistance Service Devices (PASD)" dated March 2012, PASDs were to be monitored and evaluated (but did not indicate by whom) and that "the care plan was to be followed". The bed rails, which were assessed for use when in bed (unless otherwise specified) and documented in the resident's plan of care, were therefore not "lowered" or left unapplied as required by their plan of care.

(#2) Bed System Evaluations

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The document includes detailed instructions on how to evaluate bed systems and outlines challenges associated with bed systems with unique mattresses.

A. According to the Director of Maintenance and Properties (DMP), all beds were evaluated or measured using a specialized weighted tool identified in the HC guidelines in April and August 2016. When reviewed, the documented results of the bed system evaluations did not include any beds that failed entrapment zones 1 through 4. Upon further review, the documents were missing unique identifying codes or serial numbers for the bed frames tested and the records did not include the size or type of bed rail that was attached to the bed when tested. Bed systems that were observed during the inspection in various resident rooms that were suspected of not passing entrapment, could not be verified against the records. The entrapment status of any bed at the time of inspection could not be easily ascertained. According to the DMP, since August 2016, the home had purchased new bed systems (which were assumed to have passed entrapment zones 1 through 4 based on manufacturer's assurances) and bed rails were removed and re-attached, and not necessarily attached back onto the same bed frame. A re-evaluation of the these beds was not completed. According to the HC Guidelines, when components of the bed system are changed or replaced (mattresses, bed

rails), the bed system should be re-evaluated with the specialized tool to ensure that the zones in and around the bed rail and between the mattress and the bed rail comply with required specifications.

B. According to the documented bed safety evaluations completed in 2016, approximately five therapeutic surfaces were documented to have been measured and that they passed entrapment zones 2, 3 and 4.The assessor who conducted the measurements was no longer employed by the home to determine how the bed system was measured or evaluated. According to the HC Guidelines, therapeutic surfaces are not able to be tested due to the technical difficulties with measuring certain dimensional gaps in these types of compressible products and are often times wider or longer than the deck of the bed. Such surfaces/mattresses are therefore not tested and must be managed as a "failed" bed system and would need to include a thorough clinical resident assessment and appropriate accessories to mitigate the failed zones if bed rails were to remain on the bed and used by a resident. During a tour of several home areas, two beds with a therapeutic surface on the frames were observed. One identified bed frame did not include any bed rails, but the other identified bed frame located on a different floor included two bed rails, one of which was elevated. This particular bed, although unoccupied at the time of observation, was confirmed to be very soft and when pressed along the edge and a large gap became evident under the lowest rung of the bed rail and between the bed rail and the therapeutic surface. No bolsters or other gap-filling accessories were on the bed or in the bedroom. According to several PSWs, the resident, when in bed had both bed rails in place and the information was included in their written plan of care. Due to concerns regarding the safety of the resident, discussion was held with the Chief Nursing Officer and Director of Nursing and Resident Care, who had removed the therapeutic mattress and replaced it with a foam mattress, but was not re-measured during the inspection.

Confirmation was made with several registered staff members and a non-registered staff member on November 14, 2017, that a total of nine bed frames in the home were equipped with the same type of soft therapeutic surface as noted in an identified room on an identified floor. Four of the bed systems were confirmed by registered staff to have been equipped with one or more bed rails and three of the residents that occupied those beds actively used the bed rails and who did not have any gap mitigating accessories on the bed. Discussion was held with the staff members that the entrapment status of the bed systems were suspected of being inaccurate (that beds did not pass zones 2, 3 and 4) and each resident who

was previously assessed on such a system, would not have been assessed accurately to ensure that risks associated with zones 2, 3 and 4 were mitigated as necessary.

C. The licensee's "Bed Entrapment Prevention Program" policy and procedure did not address how to evaluate and manage therapeutic surfaces, especially those with a soft, compressible mattress. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)The following order(s) have been amended:CO# 001

Issued on this 28 day of February 2018 (A4)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A4)

Inspection No. / No de l'inspection : 2017_539120_0059 (A4)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 005504-17 (A4)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Feb 28, 2018;(A4)

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5050 Hillside Drive, Beamsville, ON, L0R-1B2

LTC Home / Foyer de SLD : Albright Gardens
5050 Hillside Drive, Beamsville, ON, L0R-1B2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : William ter Harmsel

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To Albright Gardens Homes, Incorporated, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_555506_0011, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

(A4)
The licensee shall:

1. Immediately re-assess the three identified residents in accordance with "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" to determine if alternatives to bed rails can be implemented. If not, and bed rails have been determined to be beneficial, zones 2, 3 and 4 shall be mitigated by using appropriate interventions or accessories as referenced in "A Guide to Modifying Bed Systems Using Accessories to Prevent Entrapment, June 2016". All or any changes that have been implemented shall be reflected in the resident's written plan of care (i.e. the accessory or intervention shall be described, why used, when and where applied).

2. Evaluate all beds (excluding those with a compressible therapeutic

mattress) in accordance with the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". Each bed shall be identified by serial number or unique code which corresponds to the mattress. All beds that have received a new or different mattress or have had bed rails removed and re-attached to the frame shall be re-evaluated.

3. Provide face to face training to all personal support workers (PSW), that shall include, at a minimum, the following;

a) the role of the PSW in ensuring residents remain safe in the use of their bed systems; and
b) the type of sleep patterns, behaviours and risks to look for when monitoring residents while in bed with bed rails applied and how to report the observations; and
c) when bed rails are to be applied (as described in plan of care, when in bed, during care only, at all times); and
d) risks associated with applying a bed rail, especially when the resident did not meet the criteria for their application; and
e) what to report to registered staff (malfunctioning bed rails, loose bed rails, broken mattress keepers, mattresses not fitting between the mattress keepers, worn or ripped mattresses) and when; and
f) the various laws that govern bed rails in Ontario (Health Canada, MOHLTC); and
g) the use of various accessories to mitigate entrapment risks.

A record shall be kept of who participated in the training, who completed the training and what was offered in the training.

4. Amend any policy related to bed safety to include how therapeutic surfaces will be evaluated and managed and include a reference to "A Guide to Modifying Bed Systems Using Accessories to Prevent Entrapment, June 2016", or additional information as necessary to direct staff in their tasks in evaluating and mitigating bed safety risks.

Grounds / Motifs :

(A4)
1. The licensee did not ensure that where bed rails were used, that (#1) the resident was assessed in accordance with prevailing practices to minimize risk to the

resident, and (#2) the resident's bed system was evaluated in accordance with prevailing practices to minimize risk to the resident.

A Compliance Order (CO) was previously issued on June 2, 2017, for an inspection conducted in January 2017, related to the licensee's bed safety program. Three requirements were to be implemented, one was complied with, the second requirement included that all residents that used bed rails be assessed in accordance with a specified prevailing practice and the third requirement included staff education. During this follow up inspection, it was determined that residents were not adequately assessed and that bed systems were not evaluated in accordance with prevailing practices. Staff education for registered staff was completed, but was limited for personal support workers (PSWs). Action on the part of the licensee is required.

(#1) Resident Assessments

According to a prevailing practice tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be clinically assessed by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use. Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, entrapment, bruising or other skin injuries and entanglement. As such, bed rails and mattresses must be maintained in a safe condition (as per manufacturer's directions), pass all zones of entrapment (specific areas that are measured around the bed rail and mattress and the bed rail itself), and the resident must be clinically assessed to determine if they are able to understand and safely use the bed rails to minimize any inherent risks to themselves. For therapeutic surfaces, additional considerations must be included if bed rails will be used as the surfaces do not all have a firm perimeter edge and can be very compressible in nature. These types of surfaces cannot be measured for entrapment zones and as such, the risks are inherently greater for residents who are placed on them. Residents may benefit from the surface, but those at risk of entrapment due to bed rail application must be assessed with greater restrictions and employ the prevailing guidelines titled "A Guide to Modifying Bed Systems Using Accessories to Reduce

the Risk of Entrapment, June 2006" (developed by the US Food and Drug Administration and adopted by Health Canada).

A. Resident #100 and three additional identified residents, all of whom were confirmed by the RAI-MDS Coordinator and registered staff to have been provided with a therapeutic surface and who used one or more bed rails were at risk of entrapment. The surfaces were all soft and compressible and therefore did not pass entrapment testing. No accessories were included in the mitigation of these entrapment risks.

Resident #100 was admitted to the home in 2017, and placed on a standard foam-based mattress which passed entrapment testing in 2016. They were assessed two months later, as requiring one bed rail. According to the RN who completed the "Bed Rail Use Assessment Form", the resident requested the use of the bed rail (rather their Substitute Decision Maker - SDM) for repositioning and was identified to have only one risk factor for injury when bed rails were applied. The alternatives that were listed on the form were not selected and no documentation as to why the bed rail was not trialled. According to progress notes made by an RN, the SDM insisted that one bed rail be applied despite the potential risks explained to them. As part of the assessment process, a "Night Bed Rail Observation" form was to have been completed by night staff for three nights, which required staff to observe the resident for risks while bed rails were applied. However the forms located in the resident's chart for each night were not completed.

According to the prevailing practices, residents are to be re-assessed when a change in their condition occurs and/or when their bed system is changed. In 2017, both the resident's condition and their bed system changed. The resident fell and injured themselves and was transported to hospital. They were re-admitted to the home, and although not documented, several staff members who knew the resident recalled that the therapeutic surface was provided shortly after arriving from hospital. According to the resident's clinical record after being re-admitted to the home from hospital, registered staff documented that the resident had behaviours and symptoms, which increased their potential risk of a bed rail related injury and was found on the floor several times. For three nights, the "Night Bed Rail Observation" forms, identified that the resident slept in a position that placed the resident at potential risk of a bed related injury. A "Bed Rail Use Assessment" form could not be located in the resident's chart. The plan of care was not revised to include the intervention of the therapeutic surface, the reason for it's implementation or date implemented. No

progress notes were made regarding the use of the therapeutic surface. There was no information in the resident's clinical record regarding their ability to continue to use bed rails safely while on a different surface, one that reacted to the residents weight and movements very differently than that of a standard foam mattress. The risk over the benefits of continuing to use bed rails was not identified, no alternatives were listed as trialled before applying the bed rails while on a therapeutic surface and no accessories were listed as being necessary to mitigate any entrapment zones.

During the inspection, the therapeutic surface (which was very soft and compressible) was observed on the resident's bed frame whereby one bed rail was elevated or applied (resident was not in bed). According to the resident's most current written plan of care, two bed rails were to be applied when the resident was in bed for a specified reason, but not for bed mobility or transfers. No other information was included, such as the need for accessories necessary to mitigate identified risk factors such as bed rail injury or possible entrapment.

Discussion held with the nursing management team revealed that they were unaware of when the therapeutic surface was applied and were not aware that the written plan of care did not include the details of the intervention. The resident was re-assessed during the inspection, and the DOC reported that the surface would be removed by end of day as it was not required. However, no indication was made if the bed was re-measured after the foam mattress was re-applied.

B. The clinical guidance document emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The process was also repeated in the licensee's bed safety and use of restraints policies and procedures. The licensee's "Bed Rail Use Assessment" Form included an "alternatives" section for completion by the RN, however no provisions were made on the form itself to document the date(s) trialled and the outcome, or space to include any other note related to why they were not trialled. The options on the form included several interventions such as low bed, scheduled toileting, increased monitoring and restorative care, but no actual bed rail alternatives. The interventions listed are options that can be implemented with or

without bed rails in place. No bed rail alternatives were listed such as perimeter reminders, positioning rolls, roll guards, raised or lipped mattresses, or soft rails/bolsters. When discussed with the Director of Nursing and Chief Nursing Officer, about availability in the home of these alternatives, positioning pillows or body pillow, bolsters and raised perimeter mattresses were available, but were not included as an alternative to the use of bed rails, but for other purposes. Out of the seven residents selected for review, none included any information on their "Bed Rail Use Assessment" form about the use of any alternatives or the interventions (if selected), or any documentation that described why they were not implemented if not appropriate.

C. Residents #100, 101, 102, 103 and 104 were not in bed during the inspection, but each of their bed systems had one or more bed rails elevated or "applied". According to the written plan of care for each resident, bed rails were identified to be a personal assistance services device (PASD) and were to be applied while the resident was in bed. During a tour of the home, a total of 40 additional unoccupied bed systems were observed to have one or more bed rails elevated or applied and most were covered by the bed spread. According to a personal support worker (PSW), the bed rails were supposed to be left "down" when the resident was assisted out of bed in the morning and that out of habit, some staff had left them "elevated" all day. It was determined through discussions with various staff, that some beds were made by non-nursing staff and they may not have been aware of the home's policy on the application of PASDs.

According to a notice titled "Bed Rail Policy - Direction to PSW", which was posted on a bulletin board on May 12, 2017, within each home area, direction was given to PSWs that included that "bed rails only be applied if assessment warrants their use and they have been included in a care plan". The home's policy titled "Use of Personal Assistance Service Devices (PASD)" dated March 2012, PASDs were to be monitored and evaluated (but did not indicate by whom) and that "the care plan was to be followed". The bed rails, which were assessed for use when in bed (unless otherwise specified) and documented in the resident's plan of care, were therefore not "lowered" or left unapplied as required by their plan of care.

(#2) Bed System Evaluations

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance

Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The document includes detailed instructions on how to evaluate bed systems and outlines challenges associated with bed systems with unique mattresses.

A. According to the Director of Maintenance and Properties (DMP), all beds were evaluated or measured using a specialized weighted tool identified in the HC guidelines in April and August 2016. When reviewed, the documented results of the bed system evaluations did not include any beds that failed entrapment zones 1 through 4. Upon further review, the documents were missing unique identifying codes or serial numbers for the bed frames tested and the records did not include the size or type of bed rail that was attached to the bed when tested. Bed systems that were observed during the inspection in various resident rooms that were suspected of not passing entrapment, could not be verified against the records. The entrapment status of any bed at the time of inspection could not be easily ascertained. According to the DMP, since August 2016, the home had purchased new bed systems (which were assumed to have passed entrapment zones 1 through 4 based on manufacturer's assurances) and bed rails were removed and re-attached, and not necessarily attached back onto the same bed frame. A re-evaluation of the these beds was not completed. According to the HC Guidelines, when components of the bed system are changed or replaced (mattresses, bed rails), the bed system should be re-evaluated with the specialized tool to ensure that the zones in and around the bed rail and between the mattress and the bed rail comply with required specifications.

B. According to the documented bed safety evaluations completed in 2016, approximately five therapeutic surfaces were documented to have been measured and that they passed entrapment zones 2, 3 and 4.The assessor who conducted the measurements was no longer employed by the home to determine how the bed system was measured or evaluated. According to the HC Guidelines, therapeutic surfaces are not able to be tested due to the technical difficulties with measuring certain dimensional gaps in these types of compressible products and are often times wider or longer than the deck of the bed. Such surfaces/mattresses are therefore not tested and must be managed as a "failed" bed system and would need to include a thorough clinical resident assessment and appropriate accessories to mitigate the failed zones if bed rails were to remain on the bed and used by a

resident. During a tour of several home areas, two beds with a therapeutic surface on the frames were observed. One identified bed frame did not include any bed rails, but the other identified bed frame located on a different floor included two bed rails, one of which was elevated. This particular bed, although unoccupied at the time of observation, was confirmed to be very soft and when pressed along the edge and a large gap became evident under the lowest rung of the bed rail and between the bed rail and the therapeutic surface. No bolsters or other gap-filling accessories were on the bed or in the bedroom. According to several PSWs, the resident, when in bed had both bed rails in place and the information was included in their written plan of care. Due to concerns regarding the safety of the resident, discussion was held with the Chief Nursing Officer and Director of Nursing and Resident Care, who had removed the therapeutic mattress and replaced it with a foam mattress, but was not re-measured during the inspection.

Confirmation was made with several registered staff members and a non-registered staff member on November 14, 2017, that a total of nine bed frames in the home were equipped with the same type of soft therapeutic surface as noted in an identified room on an identified floor. Four of the bed systems were confirmed by registered staff to have been equipped with one or more bed rails and three of the residents that occupied those beds actively used the bed rails and who did not have any gap mitigating accessories on the bed. Discussion was held with the staff members that the entrapment status of the bed systems were suspected of being inaccurate (that beds did not pass zones 2, 3 and 4) and each resident who was previously assessed on such a system, would not have been assessed accurately to ensure that risks associated with zones 2, 3 and 4 were mitigated as necessary.

C. The licensee's "Bed Entrapment Prevention Program" policy and procedure did not address how to evaluate and manage therapeutic surfaces, especially those with a soft, compressible mattress

This Compliance Order is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope (pervasiveness), severity (of the harm or risk of harm) and history of non-compliance. In relation to s. 15(1) of Ontario Regulation 79/10, the scope of the non-compliance included a pattern, as some of the residents who were provided with therapeutic surfaces were also using one or more bed rails and were not assessed in accordance with prevailing practices, the severity of the non-compliance had the potential to cause harm to residents related to their bed systems and the history of

non-compliance included a Compliance Order that was issued under the same section on June 2, 2017 for an inspection conducted in January 2017. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Mar 31, 2018(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28 day of February 2018 (A4)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK - (A4)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Hamilton