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 sous *la Loi de 2007 sur 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 5, 2019	2019_565647_0006	030953-18, 000453-19, 000467-19, 005115-19, 005144-19	Critical Incident System

Licensee/Titulaire de permis

The Board of Management for the District of Nipissing East
400 Olive Street NORTH BAY ON P1B 6J4

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

Cassellholme
400 Olive Street NORTH BAY ON P1B 6J4

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

JENNIFER BROWN (647), SHANNON RUSSELL (692), TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 18 - 22, 2019.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
-one intake was related to a bed entrapment which resulted in injury,
-one intake was related to staff to resident abuse,
-one intake was related to resident to resident abuse, and
-two intakes were related to a fall with fracture.

A Complaint Inspection #2019_565647_0007 was conducted concurrently with this CIS Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Clinical Services (DOCS), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Support Outreach staff (BSO), Schedule Coordinator for Clinical Services, Maintenance Manager, Personal Support Workers (PSWs), Residents, and Substitute Decision Makers (SDM).

During the course of this inspection, the Inspector(s) conducted observations in resident home areas, care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **3 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) the restraining of the resident was included in the resident's plan of care.

The licensee submitted a Critical Incident (CI) report to the Director, for an incident that caused an injury to a resident in which they were transferred to the hospital, and resulted in a significant change in the resident's health status.

Inspector #692 reviewed the CI report, which indicated that on an identified date, resident #002 had complained of lower extremity pain, denying a fall within the home. Resident #002 was transferred to the hospital and was diagnosed with a lower body injury. A further review of the CI report indicated that a specified intervention was implemented upon resident #002's return to the home.

Inspector #692 observed resident #002 with the specified intervention in place.

During an interview with Inspector #692, resident #002 stated that a specified intervention had been put into place when they returned from the hospital. The resident further stated that when the specified intervention was implemented, it prevented them from performing an identified activity of daily living (ADL).

A review of the licensee's policy titled, "Restraint and Personal Assistance Service Devices (PASDs)" #R6.2.0, last reviewed July 9, 2015, indicated that the definition of a physical restraint was "any physical or mechanical device, material or equipment that was attached or adjacent to the residents body, that the resident cannot remove and that restricts the residents freedom of movement or normal access to their body". The policy further indicated that the resident was to be both physically and cognitively able to release themselves with the use of a physical restraining device and outlined the requirements that included identification in the resident's plan of care if there was the usage of a physical restraint.

Inspector #692 conducted a review of resident #002's health care record. During a review of the resident's current electronic plan of care, in effect at the time of the inspection, the Inspector was unable to locate a focus for the identified intervention, as well as there was not any evidence of assessments, consenting, monitoring or documentation related to the usage of this intervention.

During staff interviews with Personal Support Worker (PSW) #120 and Registered staff member #117, they both confirmed that staff were to refer to the resident's plan of care in order to provide the resident the individualized care that they required. Both the PSW and the Registered staff member confirmed that resident #002 had a specified intervention, which was used to prevent the resident from performing an ADL. They both verified that resident #002 was not physically able to remove the specified intervention themselves when it was in place.

In a separate interview with Registered staff member #117, they indicated that the specified intervention for resident #002 should be in the plan of care, however, it was not indicated in their plan of care.

Inspector #692 interviewed Registered staff member #118, in which they indicated that there were specified requirements to be in the plan of care for all residents that have the specified intervention in place. Registered staff member #118 further indicated that resident #002 had the specified intervention in place. Registered staff member #118 confirmed that if resident #002 was unable to remove the specified intervention themselves, then it should have been identified in their plan of care. [s. 31. (1)]

2. Inspector #692 observed resident #006 with a specified intervention in place.

During an interview with Inspector #692, resident #006 was unable to remove the specified intervention.

Inspector #692 conducted a review of resident #006's plan of care and was unable to locate a focus for identified intervention, as well as there was not any evidence of assessments, consenting, monitoring or documentation related to the usage of the specified intervention.

During an interview with PSW #115, they confirmed that resident #006 had a specified intervention so they would not be able to perform an ADL. They further stated that the

use of the specified intervention was not in the resident's plan of care.

In an interview with Inspector #692, Registered staff member #102 stated that they believed resident #006 was unable to remove the specified intervention and would not be able to perform an identified ADL, if they chose to, when the specified intervention was in place. Registered staff member #102 confirmed that the use of the specified intervention was not indicated in their plan of care, and it should have been.

Inspector #692 interviewed Registered staff member #118, who indicated that there were specified requirements to be in the plan of care for all residents that have the specified intervention in place. Registered staff member #118 confirmed that resident #006 had the specified intervention in place to prevent them from performing an ADL. Together, Inspector #692 and Registered staff member #118 reviewed resident #006's current electronic plan of care and Registered staff member #118 confirmed that the specified intervention was not included in the plan of care and that it should have been. [s. 31. (1)]

3. Inspector #692 observed resident #007 with a specified intervention.

During an interview with resident #007, Inspector #692 observed that they were unable to follow directions, and were unable to remove the specified intervention.

Inspector #692 conducted a review of resident #007's plan of care and was unable to locate a focus for the specified intervention, as well as there was not any evidence of assessments, consenting, monitoring or documentation related to the usage of the specified intervention.

During an interview with PSW #115, they confirmed that resident #007 had a specified intervention, to prevent them from an identified ADL. PSW #115 confirmed that resident #007 was not able to remove the specified intervention by themself. They further stated that the use of the specified intervention was not in the residents' plan of care, and that staff just implemented it to stop them from performing an ADL.

In an interview with Inspector #692, Registered staff member #102 indicated that they did not believe resident #007 had the application of the specified intervention as they did not monitor or document on the use of it. Registered staff member #102 confirmed that resident #007 would not be able to remove the specified intervention themselves. Registered staff member #102 confirmed that the use of the specified intervention was not indicated in their plan of care, and it should have been when they had a specified

intervention in place that prevents them from performing an ADL.

Inspector #692 interviewed Registered staff member #118, who confirmed that resident #007 had the specified intervention in place however was not aware of the reason for it. Together, Inspector #692 and Registered staff member #118 reviewed resident #007's current electronic plan of care and Registered staff member #118 confirmed that the specified intervention was not included in their care plan, and that it should have been.

During an interview with the Director of Clinical Services (DOCS), they indicated to Inspector #692 that any resident that had the specified intervention, was to be included in their plan of care. The DOCS confirmed that staff were unable to know the proper application of the intervention, how often to implement it, how to monitor and how to document the use of the intervention if it was not included in their plan of care. The DOCS confirmed that the usage of the specified intervention for residents #002, #006, and #007, were not being considered, as they were unable to remove the intervention themselves, and that it was not included in their plan of care. [s. 31. (1)]

Additional Required Actions:

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

WN #2: 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 :

1. The licensee has failed to ensure that where bed rails were used, the resident was

assessed and that the residents' bed system was evaluated in accordance with prevailing practices to minimize risk to the resident.

A CI report was submitted to the Director, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #004 had swelling and pain to an identified upper body part and had disclosed to a family member that they had got an identified upper body part caught in an identified device.

On August 21, 2012, a notice was issued to the Long Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "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 and provides clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also included the title of a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006" The guide included information with respect to the various options and corrective strategies available to mitigate entrapment zones, a guide to buying beds, how to inventory bed systems and reviewed the dimensional criteria of bed systems. The documents are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

A) Inspector #690 requested a copy of the most recent evaluation of the bed systems in the home. The Maintenance Manager (MM) provided the Inspector with an identified document. The document included information on the room number that the bed was in, a bed number to identify the bed, the rail type, type of bed frame, mattress type and the date that the bed rails were last evaluated for risk of entrapment. The MM indicated to the Inspector that the document was up to date and that at the time of inspection, all beds in the home passed the entrapment test.

A review of the Facility Entrapment Inspection sheet indicated that there were 240 beds identified on the list. The inspection sheet indicated that there was one bed on the list that was last tested in 2015, eight beds that were last tested in 2016, 50 beds that were last tested in 2017, and for 67 of the beds on the list, the column to indicate the date that

the beds were last tested was blank. The list did not identify what zones of the bed were tested, whether the zones passed or failed and if there were any corrections made to address any zones that failed.

A review of the home's policy titled "Bed Safety-Red Tag Safety Assessment", policy #B18.0, last revised March 21, 2018, indicated that the Red Tag Safety Assessment Checklist for clinical, housekeeping and maintenance staff was to be completed within four hours of an equipment change or admission.

The Maintenance Manager (MM) indicated that the "Red Tag Safety Assessment Checklist" would indicate that all zones were checked and considered safe. The MM identified that beds were only tested when there was a change in equipment such as a change in mattress or bed frame. The beds were not tested for potential zones of entrapment for all new admissions unless there was a change in the bed frame or mattress. The MM acknowledged that over time, the bed rails can loosen or mattresses can wear out, causing the gap in zone two to widen and present an entrapment risk. The MM indicated that beds should be evaluated annually to ensure that rails haven't loosened and to ensure the mattress is the proper thickness. The MM further indicated that the home did not have a mattress identifier system in place, such as a number on the mattress to identify which mattress was tested with each bed. The MM could not verify that the last bed evaluation recorded for each bed, was done with the same mattress that was currently on the beds.

A review of the red tag assessments for resident #004's bed upon admission, which was the bed that the incident with resident #004 occurred in, indicated that the bed was not tested for entrapment at the time of admission for resident #004 or after the reported incident occurred. The HCG indicated that a resident's needs should be re-assessed and the equipment re-evaluated immediately if there was an episode of entrapment or near-entrapment, with or without serious injury as fatal "repeat" events can occur within minutes of the first episode. The MM indicated that to date, resident #004's bed had not been re-evaluated for potential risk of entrapment.

In an interview with Inspector #690, the DOCS indicated that all beds in the home should be evaluated yearly, on all new admissions and with any equipment changes made to the mattress or bed. The DOCS acknowledged that the Facility Entrapment Inspection Sheet, that was provided to the Inspector was the record of the annual evaluations of the beds, and that all beds should have been evaluated in 2018. The DOCS further indicated that resident #004's bed should have been re-evaluated after the entrapment incident

and that it was not.

B) The facility entrapment inspection sheet and the red tag safety assessment did not indicate which zones were tested and if a rotating assist rail was tested in both locking positions. A rotating assist rail is a type of rail that rotated 180 degrees. The bed system was designed to lock and stop in two main positions, a transfer position (vertical) and a guard position (horizontal). The transfer position offered the resident the ability to get in and out of bed easily and the guard position was designed to assist residents with bed repositioning, while in bed, and provide a bed edge reminder. According to HCG, bed rails must be evaluated with the cone and cylinder tool in all available locking positions.

Inspector #690 observed a bed evaluation of an identified bed with the MM completing the bed evaluation and the DOCS present. The bed was equipped with two rotating assist rails on either side of the bed, both in the guard position. The MM performed the bed evaluation on the bed rail closest to the window on the bed. All four zones were tested. The MM indicated that they would then test the other side of the bed in the same manner. The MM confirmed that the test was complete. The bed rail was not tested in the assist position until after the Inspector requested that the MM demonstrate the evaluation in the assist position. The large end of the cone entered the space below the rail when the rail was placed in the assist position, indicating a fail of zone two. The MM indicated that they would test the bed rails in all locking positions, but had no records to indicate that it had been done.

Inspector #690 observed a bed evaluation of an identified bed. The bed was equipped with two rotating assist bed rails one on either side of the bed. The MM performed the bed evaluation on the rail closest to the door and the bed failed zone two when the rail was in the assist position. The Inspector pointed out concerns to the MM and the DOCS related to the following beds:
-one bed had two quarter length rotating assist rails, one on either side of the bed, both in the assist position, the bed rail closest to the door was loose, there was a large gap between the mattress and bed rail;
-one bed had two quarter length rotating assist rails on either side of the bed, the rail closest to the window was in the guard position and the rail closest to the door was in the assist position. The bed was equipped with a metal mattress keeper at the head and foot of the bed. The mattress rested on top of the mattress keeper at the foot of the bed that caused the mattress to shift away from the rail. This caused a large gap between the mattress and the bed rail;
-one bed had two quarter length rotating assist rails on either side of the bed. The bed

was equipped with a metal mattress keeper. The mattress was resting on top of the mattress keeper at the foot of the bed, which caused the mattress to shift away from the bed rail, and created a large gap between the bed frame and mattress. The MM indicated that they suspected that many more beds in the home would fail zone two related to loose rails or a shifting mattress as the mattress would sit on top of the mattress keepers;
-one bed had two three quarter length fixed bed rails on the bed. The mattress was a low air loss pressure reducing mattress indicated as a High Intensity Needs (HIN) mattress on the Facility Entrapment Inspection sheet. There were gaps noted in between the mattress and the bed rails on both sides. There were no modifications made to the bed or mattress to minimize the gap. There were 17 beds identified on the Facility Entrapment Inspection sheet. The MM indicated that beds with air mattresses are not tested as they all fail the bed entrapment evaluation. The DOCS, who was present at the time of the observation, indicated that there should have been modifications made such as a gap filler to reduce the gap between the mattress and the bed rail.

In an interview with Inspector #690, the DOCS indicated that all beds should be tested annually and that the home should have had a record of the bed evaluations that included what zones passed or failed and what was done to correct any beds that failed the test. The DOCS further indicated that is was unclear if all beds with rotating assist rails were tested in the assist position as there were no records of any of the zones that were tested, what position the rail was in, and that there was no tracking of what mattress was tested with the bed frame, as the mattresses were not numbered. The DOCS identified that the beds were not evaluated according to prevailing practices and that they should have been.

2. The licensee's bed rail use clinical assessment form and process was reviewed and it was determined by Inspector #690, that it was not fully developed in accordance with the Clinical Guidance document identified in the above mentioned notice issued to Long Term Care Home Administrators. The companion documents referenced in the notice are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who use one or more bed rails, were to be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. Where bed rails are used for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing risks, and

implemented where necessary. The assessment guideline offers examples, key assessment questions that guides decision-making, such as the resident's history of falls from a bed, previous bed rail use, communication limitations, their mobility, cognitive status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors and the entrapment status of the resident's bed.

The guidance document also emphasized the need to document clearly whether alternatives to bed rails were used 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 the Substitute Decision Maker (SDM) and any other interdisciplinary team members, would be made about the necessity and safety of the bed rail use for a particular resident and details documented on a form (electronically or paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the resident or the SDM), the size or type of the rail to be applied (rotating assist, fixed assist, 1/4, 1/2, 3/4 bed rail), when the bed rails are to be applied, how many bed rails, on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

Inspector #690 reviewed the above mentioned CI report and conducted a review of resident #004's health records, which identified a document, that was completed on the day of admission to the home. The identified document indicated that resident #004 had an identified device to assist with an activity of daily living (ADL). The bed rail safety risk assessment did not include a component related to evaluating the resident's sleep pattern, habits and behaviours while sleeping in bed, medication use, toileting patterns or pain with or without the application of the bed rails. The bed rail risk assessment did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative. The assessment did not include information on the type of rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on. [s. 15. (1) (a)]

2. Resident #008's bed was observed by Inspector #690 to have an identified device.

Inspector #690 reviewed health records for resident #008 and identified that a specified assessment was conducted on the day of admission to the home. The assessment indicated that the identified device was in place due to the request of the resident and the

Substitute Decision Maker (SDM). The specified assessment did not include a component related to evaluating the resident's sleep pattern, habits and behaviours while sleeping in bed, medication use, toileting patterns or pain with or without the use of the identified device. The assessment did not include a component to indicate that alternatives to the identified device had been attempted and the effectiveness of the alternative. [s. 15. (1) (a)]

3. Resident #001 was observed by Inspector #692 to have a specific bed rail configuration. The mattress was a specialty air mattress and the resident was in bed at the time of the observation.

Inspector #692 reviewed health records for resident #001 and identified a bed rail risk assessment completed on the day of admission. The bed rail risk assessment indicated that there were two specific bed rails to be engaged when resident #001 was in bed at all times, and that the bed rails were in place at the request of the resident and SDM and to assist with bed mobility. A further review of resident#001's health records identified a bed rail risk assessment was completed, that indicated that the assessment was completed due to a change in equipment and the bed rails were in place at the request of the resident and SDM and for bed mobility. The bed rail safety risk assessments did not include a component related to evaluating the resident's sleep pattern, habits and behaviours while sleeping in bed, medication use, toileting patterns or pain with or without the application of the bed rails. The bed rail risk assessment did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative. The assessment did not include information on the type of rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on. [s. 15. (1) (a)]

4. A review of the home's policy titled "Bed Rail Assessment-Procedure", # B16.0, last revised on August 17, 2018, indicated that the policy was to be used by the registered nurse as a means to assess the need for bed rails and to complete a comprehensive assessment of the benefits and risks for the resident when bed rails are used or not used. The policy did not include the role for the care giver or PSW in providing essential information to the RN about the resident risks of bed rail use, night time habits, behaviours, bed mobility and sleep patterns. No information was included as to how resident safety would be assessed while in bed. The procedures did not include how long the resident would be observed while in bed (with or without the rails, the length of time residents would be monitored with or without the rails, what alternatives needed to be trialed before deciding that the rails were an ideal option and for how long, who would

monitor residents during the night and how often, what specific hazards would be monitored for and subsequently documented and how specifically team members would participate in assisting the RN in making a final decision about the benefits versus the risk of the resident's bed rails.

In separate interviews with Inspector #690, PSW's #112 and #121 indicated that they do not participate in the bed rail assessments of any residents. They indicated that they do not observe residents in bed with respect to sleep patterns or habits, movement patterns, behaviours, pain or toileting patterns with or without the use of bed rails.

In a interview with Inspector #690, Registered staff member # 117 indicated that they do not participate in the bed rail assessments of any residents. They indicated that they do not observe residents in bed with respect to sleep patterns or habits, movement patterns, behaviours, pain or toileting patterns with or without the use of bed rails.

In an interview with Inspector #690, Registered staff member #118 indicated that they are responsible for completing the bed rail risk assessments for residents upon admission, with any change in the resident's bed system or a significant change in a resident's status. Registered staff member #118 indicated that there is no observation of a resident with respect to sleep patterns or habits, movement patterns, behaviours, pain or toileting patterns with or without the use of bed rails, and that most residents have bed rails on the bed at the time of admission. Registered staff member #118 further indicated that alternatives to bed rails are not attempted prior to the application of bed rails.

In an interview with Inspector #690, the DOCS indicated that they were aware of the HCG documents, but not what was included in the documents related to the clinical assessment of the resident regarding the use of bed rails. The DOCS indicated that the home's process for assessing the risk versus benefit use of the bed rails does not include an observation of residents in bed with respect to sleep patterns or habits, movement patterns, behaviours, pain or toileting patterns with or without the use of bed rails. The assessment is completed solely by the RN's in the home, with no input from the PSW's or other team members. The DOCS also identified that the home does not attempt alternatives to the use of bed rails, prior to the application of bed rails and that the home's process for completing the bed rail risk assessment was not done in accordance with the current prevailing practices for all residents. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CI report was submitted to the Director on an identified date, for Improper/Incompetent treatment of a resident that resulted in harm or risk of harm related to an allegation of neglect of resident #005 that occurred four days prior.

A review of the CI report identified that resident #005 had a fall and had been found several hours later by the next shift. Resident #005 was transferred to the hospital and was treated with an upper body injury. The CI report further indicated that the home's internal investigation identified that a PSW did not complete hourly rounds which resulted in resident neglect.

A review of resident #005's electronic progress notes indicated that the resident was found on the floor, and was noted to have upper body injuries.

A review of resident #005's electronic plan of care indicated that staff were to check the resident every hour to ensure the resident's safety.

In an interview with Inspector #690, PSW #114 indicated that they were working on a specified shift and was responsible for resident #005's care. PSW #114 indicated that staff were to do hourly checks on all residents, and that they were responsible to complete the hourly checks for resident #005 on the identified date. PSW #114 further indicated that resident #005 was at a risk for safety and required close monitoring. The PSW indicated that they did not complete hourly rounds on resident #005 on the identified shift, and that they should have.

In an interview with Inspector #690, Registered staff member #108 indicated that they were working the following shift to the above incident, when they were called to resident #005's room to complete a head to toe assessment. Registered staff member #108 further indicated that there was obvious upper body injuries to resident #005 and that they had concerns about how long resident #005 had gone without being monitored.

In an interview with the DOCS, they indicated that the home's internal investigation indicated that PSW #114 did not complete hourly rounds on resident #005 as specified in the plan of care for resident #005. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that neglect had occurred, immediately reported the suspicion and the information upon which it is based to the Director.

A CI report was submitted to the Director on an identified date, for Improper/Incompetent treatment of a resident that resulted in harm or risk of harm related to an allegation of neglect of resident #005 that occurred four days prior.

A review of the CI report identified that resident #005 had a fall and had been found several hours later by the next shift. Resident #005 was transferred to the hospital and was treated with an upper body injury. The CI report further indicated that the home's internal investigation identified that a PSW did not complete hourly rounds which resulted in resident neglect.

A review of the home's policy titled "Abuse, Neglect and Retaliation Prevention" policy #05-03, last revised July 5, 2018, indicated that any alleged abuse or neglect is to be reported to the Ministry of Health and Long Term Care (MOHLTC) immediately utilizing the Critical Incident System (CIS) report during business hours and by utilizing the after hours number outside of business hours.

In an interview with Inspector #690, the DOCS indicated that they were made aware of the allegation of neglect of resident #005 on the day it occurred and that they had started an immediate investigation into the allegation. The DOCS could not indicate why the CI report was first submitted to the Director four days after, and that the allegation of neglect should have been reported to the Director immediately. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Inspector #690 requested a copy of the last annual evaluation of the home's zero tolerance of abuse policy and program. Inspector #690 was provided with a document titled "Annual Evaluation of CIS abuse incidents for 2017". No other documentation was provided to the Inspector.

In an interview with Inspector #690, the DOCS could not recall when the last evaluation was completed to determine the effectiveness of the licensee's policy to promote zero tolerance for abuse was completed. The DOCS indicated that the only record of a review was the list of CI reports submitted for 2017 and an analysis of the incidents that was provided to the Inspector. The DOCS further indicated that there was no review of the policy, who attended the review, and any changes or improvements that were implemented and that the home should have been. [s. 99. (b)]

Issued on this 9th day of April, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BROWN (647), SHANNON RUSSELL (692), TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2019_565647_0006
Log No. / No de registre :	030953-18, 000453-19, 000467-19, 005115-19, 005144-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 5, 2019
Licensee / Titulaire de permis :	The Board of Management for the District of Nipissing East 400 Olive Street, NORTH BAY, ON, P1B-6J4
LTC Home / Foyer de SLD :	Cassellholme 400 Olive Street, NORTH BAY, ON, P1B-6J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Lowery

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To The Board of Management for the District of Nipissing East, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Order / Ordre :

The licensee must be compliant with s. 31 (1) of the LTCHA.
Specifically, the licensee shall:
1. Ensure that if residents are restrained by a physical device as describe in paragraph three of subsection 30 (1), the restraining device of the resident is included in their plan of care.
2. Ensure that all staff that provide direct care to residents are educated/re-educated on the process of restraining residents and the requirements to be in the plan of care.
3. Maintain a record of the training provided, including dates, times, attendees, trainers and material taught.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) the restraining of the resident was included in the resident's plan of care.

The licensee submitted a Critical Incident (CI) report to the Director, for an incident that caused an injury to a resident in which they were transferred to the hospital, and resulted in a significant change in the resident's health status.

Inspector #692 reviewed the CI report, which indicated that on an identified date, resident #002 had complained of lower extremity pain, denying a fall within the home. Resident #002 was transferred to the hospital and was diagnosed with a lower body injury. A further review of the CI report indicated that a specified intervention was implemented upon resident #002's return to the home.

Inspector #692 observed resident #002 with a specified intervention in place.

During an interview with Inspector #692, resident #002 stated that a specified intervention had been put into place when they returned from the hospital. The resident further stated that when the specified intervention was implemented, it prevented them from performing an identified activity of daily living (ADL).

A review of the licensee's policy titled, "Restraint and Personal Assistance Service Devices (PASDs)" #R6.2.0, last reviewed July 9, 2015, indicated that the definition of a physical restraint was "any physical or mechanical device, material or equipment that was attached or adjacent to the residents body, that the resident cannot remove and that restricts the residents freedom of movement or normal access to their body". The policy further indicated that the resident was to be both physically and cognitively able to release themselves with the use of a physical restraining device and outlined the requirements that included identification in the resident's plan of care if there was the usage of a physical restraint.

Inspector #692 conducted a review of resident #002's health care record. During a review of the resident's current electronic plan of care, in effect at the time of the inspection, the Inspector was unable to locate a focus for the identified intervention, as well as there was not any evidence of assessments, consenting, monitoring or documentation related to the usage of this intervention.

During staff interviews with Personal Support Worker (PSW) #120 and Registered Practical Nurse (RPN) #117, they both confirmed that staff were to refer to the resident's plan of care in order to provide the resident the individualized care that they required. Both the PSW and RPN confirmed that resident #002 had a specified intervention, which was used to prevent the resident from performing an ADL. They both verified that resident #002 was not physically able to remove the specified intervention themselves when it was in place.

In a separate interview with RPN #117, they indicated that the specified intervention for resident #002 should be in the plan of care, however, it was not indicated in their plan of care.

Inspector #692 interviewed Registered Nurse (RN) #118, in which they indicated that there were specified requirements to be in the plan of care for all residents that have the specified intervention in place. RN #118 further indicated that resident #002 had the specified intervention in place. RN #118 confirmed that if resident #002 was unable to remove the specified intervention themselves, then it should have been identified in their plan of care. (692)

2. Inspector #692 observed resident #006 with a specified intervention in place.

During an interview with Inspector #692, resident #006 was unable to remove the specified intervention.

Inspector #692 conducted a review of resident #006's plan of care and was unable to locate a focus for the identified intervention, as well as there was not any evidence of assessments, consenting, monitoring or documentation related to the usage of the specified intervention

During an interview with PSW #115, they confirmed that resident #006 had a specified intervention so they would not be able to perform an ADL. They further stated that the use of the specified intervention was not in the resident's plan of care.

In an interview with Inspector #692, RPN #102 stated that they believed resident #006 was unable to remove the specified intervention and would not be able to perform an identified ADL, if they chose to, when the specified intervention was in place. RPN #102 confirmed that the use of the specified intervention was not indicated in their plan of care, and it should have been.

Inspector #692 interviewed RN #118, who indicated that there were specified requirements to be in the plan of care for all residents that have the specified intervention in place. RN #118 confirmed that resident #006 had the specified intervention in place to prevent them from performing an ADL. Together, Inspector #692 and RN #118 reviewed resident #006's current electronic plan of care and RN #118 confirmed that the specified intervention was not included in the plan of care and that it should have been.
(692)

3. Inspector #692 observed resident #007 with a specified intervention.

During an interview with resident #007, Inspector #692 observed that they were unable to follow directions, and were unable to remove the specified intervention.

Inspector #692 conducted a review of resident #007's plan of care and was unable to locate a focus for the specified intervention, as well as there was not any evidence of assessments, consenting, monitoring or documentation related to the usage of the specified intervention.

During an interview with PSW #115, they confirmed that resident #007 had a specified intervention. to prevent them from an identified ADL. PSW #115 confirmed that resident #007 was not able to remove the specified intervention by themself. They further stated that the use of the specified intervention was not in the residents' plan of care, and that staff just implemented it to stop them from performing an ADL.

In an interview with Inspector #692, RPN #102 indicated that they did not believe resident #007 had the application of the specified intervention as they did not monitor or document on the use of it. RPN #102 confirmed that resident #007 would not be able to remove the specified intervention themselves. RPN #102 confirmed that the use of the specified intervention was not indicated in their plan of care, and it should have been when they had a specified intervention in place that prevented them from performing an ADL.

Inspector #692 interviewed RN #118, who confirmed that resident #007 had the specified intervention in place, however, was not aware of the reason for it. Together, Inspector #692 and RN #118 reviewed resident #007's current electronic plan of care and RN #118 confirmed that the specified intervention was not included in their care plan, and that it should have been.

During an interview with the Director of Clinical Services (DOCS), they indicated to Inspector #692 that any resident that had the specified intervention, was to be included in their plan of care. The DOCS confirmed that staff were unable to know the proper application of the intervention, how often to implement it, how to monitor and how to document the use of the intervention if it was not included in

their plan of care. The DOCS confirmed that the usage of the specified intervention for residents #002, #006, and #007, were not being considered, as they were unable to remove the intervention themselves, and that it was not included in their plan of care.

The severity of this issue was determined to be a level two, as there was minimal harm or the potential for actual harm. The scope of this issue was a level three, as it was widespread throughout the home. The home had a level three compliance history, as they had related non-compliance with this section of the Ontario Regulation 79/10 that included:
-Voluntary plan of correction (VPC) issued August 31, 2016, (2016_336620_0019). (692)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2019

Order # / Ordre no : 002

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

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 :

The licensee must be compliant with s.15(1)(a) of O. Reg. 79/10.

Specifically, the licensee must:

a) Re-evaluate all bed systems in the home using the weighted cone and cylinder tool in accordance with "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. Specifically, the bed systems are to be evaluated for zones 2, 3 and 4, and for beds with rotating assist rails, the bed rails are to be evaluated in both the transfer (vertical position) and in the guard (horizontal) position.

b) Where one or more bed rails will be applied or attached to a bed frame, equip the bed frame with mattress keepers that will keep the mattress from sliding side to side and will allow the mattress to fit properly between the keepers (mattresses must not sit on top of the keepers).

c) Where bed rails do not pass zone 2, 3 or 4, mitigate the bed system in accordance with "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" or equip the bed systems with a different manufacturer's compatible bed mattress or bed rail that passes zones 1 to 4.

d) Educate all bed system evaluators on the requirements of the Health Canada guidelines entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, March 2008" and "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006).

e) Make available the results of the bed system re-evaluation to the interdisciplinary team who participates in assessing each resident for bed rail safety.

f) Keep accurate and detailed records as to the zones that were tested, what was done to a bed once it is initially evaluated (i.e. what specific change was made to the bed, the date the change was made, bed and mattress identifier, who made the changes, the re-evaluation date, auditor name and results).

g) Amend or update policy B18.0 entitled "Bed Safety-Red Tag Safety Assessment" to include a reference to "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006) and any additional information and guidance for bed system evaluators for a thorough evaluation.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and that the residents' bed system was evaluated in accordance with prevailing practices to minimize risk to the resident.

A CI report was submitted to the Director, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #004 had swelling and pain to an identified upper body part and had disclosed to a family member that they had got an identified upper body part caught in an identified device.

On August 21, 2012, a notice was issued to the Long Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "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 and provides clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also included the title of a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006" The guide included information with respect to the various options and corrective strategies available to mitigate entrapment zones, a guide to buying beds, how to inventory bed systems and reviewed the dimensional criteria of bed systems. The documents are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

A) Inspector #690 requested a copy of the most recent evaluation of the bed systems in the home. The Maintenance Manager (MM) provided the Inspector with a document titled "Facility Entrapment Inspection Sheet". The document included information on the room number that the bed was in, a bed number to identify the bed, the rail type, type of bed frame, mattress type and the date that the bed rails were last evaluated for risk of entrapment. The MM indicated to the Inspector that the document was up to date and that at the time of inspection, all beds in the home passed the entrapment test.

A review of the Facility Entrapment Inspection sheet indicated that there were 240 beds identified on the list. The inspection sheet indicated that there was one bed on the list that was last tested in 2015, eight beds that were last tested in 2016, 50 beds that were last tested in 2017, and for 67 of the beds on the list, the column to indicate the date that the beds were last tested was blank. The list did not identify what zones of the bed were tested, whether the zones passed or failed and if there were any corrections made to address any zones that failed.

A review of the home's policy titled "Bed Safety-Red Tag Safety Assessment", policy #B18.0, last revised March 21, 2018, indicated that the Red Tag Safety Assessment Checklist for clinical, housekeeping and maintenance staff was to be completed within four hours of an equipment change or admission.

The MM indicated that the "Red Tag Safety Assessment Checklist" would

indicate that all zones were checked and considered safe. The MM identified that beds were only tested when there was a change in equipment such as a change in mattress or bed frame. The beds were not tested for potential zones of entrapment for all new admissions unless there was a change in the bed frame or mattress. The MM acknowledged that over time, the bed rails can loosen or mattresses can wear out, causing the gap in zone two to widen and present an entrapment risk. The MM indicated that beds should be evaluated annually to ensure that rails haven't loosened and to ensure the mattress is the proper thickness. The MM further indicated that the home did not have a mattress identifier system in place, such as a number on the mattress to identify which mattress was tested with each bed. The MM could not verify that the last bed evaluation recorded for each bed, was done with the same mattress that was currently on the beds.

A review of the red tag assessments for resident #004's bed upon admission, which was the bed that the incident with resident #004 occurred in, indicated that the bed was not tested for entrapment at the time of admission for resident #004 or after the incident occurred. The HCG indicated that a resident's needs should be re-assessed and the equipment re-evaluated immediately if there was an episode of entrapment or near-entrapment, with or without serious injury as fatal "repeat" events can occur within minutes of the first episode. The MM indicated that to date, resident #004's bed had not been re-evaluated for potential risk of entrapment.

In an interview with Inspector #690, the DOCS indicated that all beds in the home should be evaluated yearly, on all new admissions and with any equipment changes made to the mattress or bed. The DOCS acknowledged that the Facility Entrapment Inspection Sheet, that was provided to the Inspector was the record of the annual evaluations of the beds, and that all beds should have been evaluated in 2018. The DOCS further indicated that resident #004's bed should have been re-evaluated after the entrapment incident and that it was not.

B) The facility entrapment inspection sheet and the red tag safety assessment did not indicate which zones were tested and if a rotating assist rail was tested in both locking positions. A rotating assist rail is a type of rail that rotated 180 degrees. The bed system was designed to lock and stop in two main positions, a

transfer position (vertical) and a guard position (horizontal). The transfer position offered the resident the ability to get in and out of bed easily and the guard position was designed to assist residents with bed repositioning, while in bed, and provide a bed edge reminder. According to HCG, bed rails must be evaluated with the cone and cylinder tool in all available locking positions.

Inspector #690 observed a bed evaluation of an identified bed with the MM completing the bed evaluation and the DOCS present. The bed was equipped with two rotating assist rails on either side of the bed, both in the guard position. The MM performed the bed evaluation on the bed rail closest to the window on the bed. All four zones were tested. The MM indicated that they would then test the other side of the bed in the same manner. The MM confirmed that the test was complete. The bed rail was not tested in the assist position until after the Inspector requested that the MM demonstrate the evaluation in the assist position. The large end of the cone entered the space below the rail when the rail was placed in the assist position, indicating a fail of zone two. The MM indicated that they would test the bed rails in all locking positions, but had no records to indicate that it had been done.

Inspector #690 observed a bed evaluation of an identified bed. The bed was equipped with two rotating assist bed rails one on either side of the bed. The MM performed the bed evaluation on the rail closest to the door and the bed failed zone two when the rail was in the assist position. The Inspector pointed out concerns to the MM and the DOCS related to the following beds:
-one bed had two quarter length rotating assist rails, one on either side of the bed, both in the assist position, the bed rail closest to the door was loose, there was a large gap between the mattress and bed rail;
-one bed had two quarter length rotating assist rails on either side of the bed, the rail closest to the window was in the guard position and the rail closest to the door was in the assist position. The bed was equipped with a metal mattress keeper at the head and foot of the bed. The mattress rested on top of the mattress keeper at the foot of the bed that caused the mattress to shift away from the rail. This caused a large gap between the mattress and the bed rail;
-one bed had two quarter length rotating assist rails on either side of the bed. The bed was equipped with a metal mattress keeper. The mattress was resting on top of the mattress keeper at the foot of the bed, which caused the mattress to shift away from the bed rail, and created a large gap between the bed frame

and mattress. The MM indicated that they suspected that many more beds in the home would fail zone two related to loose rails or a shifting mattress as the mattress would sit on top of the mattress keepers;
-one bed had two three quarter length fixed bed rails on the bed. The mattress was a low air loss pressure reducing mattress indicated as a High Intensity Needs (HIN) mattress on the Facility Entrapment Inspection sheet. There were gaps noted in between the mattress and the bed rails on both sides. There were no modifications made to the bed or mattress to minimize the gap. There were 17 beds identified on the Facility Entrapment Inspection sheet. The MM indicated that beds with air mattresses are not tested as they all fail the bed entrapment evaluation. The DOCS, who was present at the time of the observation, indicated that there should have been modifications made such as a gap filler to reduce the gap between the mattress and the bed rail.

In an Interview with Inspector #690, the DOCS indicated that all beds should be tested annually and that the home should have had a record of the bed evaluations that included what zones passed or failed and what was done to correct any beds that failed the test. The DOCS further indicated that is was unclear if all beds with rotating assist rails were tested in the assist position as there were no records of any of the zones that were tested, what position the rail was in, and that there was no tracking of what mattress was tested with the bed frame, as the mattresses were not numbered. The DOCS identified that the beds were not evaluated according to prevailing practices and that they should have been.

The severity of this issue was determined to be a level two, as there was minimal harm or the potential for actual harm. The scope of the issue was a level three, as it was widespread throughout the home. The home had a level three compliance history, as they had related non-compliance with this section of the Ontario Regulation 79/10 that included:
-Voluntary plan of correct (VPC) issued August 31, 2016, (2016_336620_0019). (690)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

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 :

The licensee must be compliant with s.15(1)(a) of O. Reg. 79/10.
Specifically, the licensee must:

1. Amend the home's existing process related to resident clinical assessments and the use of bed rails to include additional guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes and Home Care Settings" (U.S. F.D.A, April 2003) which is recommended as the prevailing practices for individualized resident assessment of bed rails. The amended process shall, at a minimum, include a process related to the following:

a. the observation of the resident while sleeping for a specified period of time, to establish their bed mobility status, medical condition, medication use, behaviours and any other relevant risk factors prior to the application of any bed rail or bed system accessory (bed remote control) or alternative to bed rails (bolster, positioning rolls, roll guards);

b. the observation and documentation of the resident while sleeping for a specific period of time, to establish any safety risks to the resident after a bed rail, accessory or alternative has been applied and deemed necessary; and

c. the alternative or alternatives that were trialed prior to applying one or more bed rails and document whether the alternative was effective or not during a specified observation period.

2. Develop or acquire information fact sheets or pamphlets identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks/hazards of bed rail use, available alternatives to bed rails, how residents are assessed upon admission, how bed systems are evaluated for entrapment zones, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails. This information shall be disseminated to relevant staff, families and residents (if residents are their own SDM).

3. Ensure that all registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of, and be able to apply expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other hazards, 2006" and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" U.S. F.D.A, April 2003, in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

4. Provide training to all relevant staff who participate in the assessment and observation of residents to establish any safety risks related to the use of bed rails and maintain a record of attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and that the residents' bed systems were evaluated in accordance with prevailing practices to minimize risk to the resident.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined by Inspector #690, that it was not fully developed in accordance with the Clinical Guidance document identified in the above mentioned notice issued to Long Term Care Home Administrators. The companion documents referenced in the notice were also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed

rails are used. One of the companion documents was titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who use one or more bed rails, were to be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. Where bed rails were used for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing risks, and implemented where necessary. The assessment guideline offers examples, key assessment questions that guides decision-making, such as the resident's history of falls from a bed, previous bed rail use, communication limitations, their mobility, cognitive status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors and the entrapment status of the resident's bed.

The guidance document also emphasized the need to document clearly whether alternatives to bed rails were used 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 the Substitute Decision Maker (SDM) and any other interdisciplinary team members, would be made about the necessity and safety of the bed rail use for a particular resident and details documented on a form (electronically or paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the resident or the SDM), the size or type of the rail to be applied (rotating assist, fixed assist, 1/4, 1/2, 3/4 bed rail), when the bed rails are to be applied, how many bed rails, on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

Inspector #690 reviewed the above mentioned CI report and conducted a review of resident #004's health records, which identified a document titled "Bed rails risk assessment", that was completed on the day of admission to the home. The bed rail risk assessment indicated that resident #004 had an identified device to assist with an ADL. The bed rail safety risk assessment did not include a component related to evaluating the resident's sleep pattern, habits and

behaviours while sleeping in bed, medication use, toileting patterns or pain with or without the application of the bed rails. The bed rail risk assessment did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative. The assessment did not include information on the type of rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on.

2. Resident #008's bed was observed by Inspector #690 to have an identified device.

Inspector #690 reviewed the health records for resident #008 and identified that a specified assessment was conducted on the day of admission to the home. The assessment indicated that the identified device was in place due to the request of the resident and Substitute Decision Maker (SDM). The specified assessment did not include a component related to evaluating the resident's sleep pattern, habits and behaviours while sleeping in bed, medication use, toileting patterns or pain with or without the application of the bed rails. The assessment did not include a component to indicate that alternatives to the identified device had been attempted and the effectiveness of the alternative.

3. Resident #001 was observed by Inspector #692 to have a specific bed rail configuration. The mattress was a specialty air mattress and the resident was in bed at the time of the observation.

Inspector #692 reviewed health records for resident #001 and identified a specified assessment completed on the day of admission. The assessment indicated that there were two specific bed rails to be engaged when resident #001 was in bed at all times, and that the bed rails were in place at the request of the resident and SDM and to assist with an ADL. A further review of resident #001's health records identified a bed rail risk assessment completed due to a change in equipment and the bed rails were in place at the request of the resident and SDM and for an ADL. The bed rail safety risk assessments did not include a component related to evaluating the resident's sleep pattern, habits and behaviours while sleeping in bed, medication use, toileting patterns or pain with or without the application of the bed rails. The bed rail risk assessment did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative. The assessment did not

include information on the type of rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on.

4. A review of the home's policy titled "Bed Rail Assessment-Procedure" # B16.0, last revised on August 17, 2018, indicated that the policy was to be used by the registered nurse as a means to assess the need for bed rails and to complete a comprehensive assessment of the benefits and risks for the resident when bed rails are used or not used. The policy did not include the role for the care giver or personal support worker (PSW) in providing essential information to the RN about the resident risks of bed rail use, night time habits, behaviours, bed mobility and sleep patterns. No information was included as to how resident safety would be assessed while in bed. The procedures did not include how long the resident would be observed while in bed (with or without) the rails, the length of time residents would be monitored with or without the rails, what alternatives needed to be trialed before deciding that the rails were an ideal option and for how long, who would monitor residents during the night and how often, what specific hazards would be monitored for and subsequently documented and how specifically team members would participate in assisting the RN in making a final decision about the benefits versus the risk of the resident's bed rails.

In separate interviews with Inspector #690, PSW #112 and PSW #121 indicated that they do not participate in the bed rail assessments of any residents. They indicated that they do not observe residents in bed with respect to sleep patterns or habits, movement patterns, behaviours, pain or toileting patterns with or without the use of bed rails.

In a interview with Inspector #690, RPN #117 indicated that they do not participate in the bed rail assessments of any residents. They indicated that they do not observe residents in bed with respect to sleep patterns or habits, movement patterns, behaviours, pain or toileting patterns with or without the use of bed rails.

In an interview with Inspector #690, RN #118 indicated that they are responsible for completing the bed rail risk assessments for residents upon admission, with any change in the resident's bed system or a significant change in a resident's status. RN #118 indicated that there is no observation of a residents with respect to sleep patterns or habits, movement patterns, behaviours, pain or toileting

patterns with or without the use of bed rails, and that most residents have bed rails on the bed at the time of admission. RN #118 further indicated that alternatives to bed rails are not attempted prior to the application of bed rails.

In an interview with Inspector #690, the DOCS indicated that they were aware of the HCG guidance documents, but not what was included in the documents related to the clinical assessment of the resident regarding the use of bed rails. The DOCS indicated that the home's process for assessing the risk versus benefit use of the bed rails does not include an observation residents in bed with respect to sleep patterns or habits, movement patterns, behaviours, pain or toileting patterns with or without the use of bed rails. The assessment is completed solely by the RN's in the home, with no input from the PSW's or other team members. The DOCS also identified that the home does not attempt alternatives to the use of bed rails, prior to the application of bed rails and that the home's process for completing the bed rail risk assessment is not done in accordance with the current prevailing practices for all residents.

The severity of this issue was determined to be a level three, as there was actual harm. The scope of this issue was a level three, as the number of incomplete bed rail assessments was widespread. The home had a level three compliance history with one or more related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10 that included:
-Voluntary plan of correction (VPC) issued August 31, 2016, (2016_336620_0019). (690)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 5th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Brown

Service Area Office /
Bureau régional de services : Sudbury Service Area Office