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 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 15, 2018	2017_539120_0067	011035-17	Follow up

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Cedarwood Village
500 Queensway West SIMCOE ON N3Y 4R4

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 1, 2017

An inspection (2017-573581-0002) was previously conducted January 13 to 30, 2017, and non-compliance identified with respect to resident clinical assessments where bed rails were used. A Compliance Order (CO) with multiple conditions was issued on February 23, 2017, with a due date of May 1, 2017. During a follow up inspection (539120-0028) conducted on May 3, 2017, the requirements were confirmed to be outstanding and the licensee's bed rail use clinical assessment form and processes were determined to not be fully developed in accordance with prevailing practices. Another CO was issued on May 30, 2017 with additional requirements. The compliance due date was August 31, 2017. During this follow-up inspection, it was determined that several requirements were not complied with.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, RAI-MDS Coordinator, Registered Nurse, Registered Practical Nurse (RPN), PSWs and residents.

During the course of the inspection, the inspector toured the home, observed resident bed systems, residents in bed, bed safety policies and procedures, staff training and education materials and attendance rates, bed system evaluation audit results, resident clinical bed rail use assessments and other clinical records.

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)**
- **1 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 :

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

A companion guide 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) provides the necessary guidance in establishing a clinical assessment where bed rails are used. It is cited in a guidance document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008" and was identified by the Ministry of Health and Long Term Care in 2012, as the prevailing practice.

An inspection (2017-573581-0002) was previously conducted January 13 to 30, 2017, and non-compliance identified with respect to resident clinical assessments where bed rails were used. A Compliance Order (CO) with multiple conditions was issued on February 23, 2017, for a due date of May 1, 2017. The CO included requirements to amend the home's existing forms to include all relevant questions and guidance related to bed safety hazards identified in the above noted Clinical Guidance document, that an interdisciplinary team assess all residents who used bed rails, and that their written plan of care be updated after being assessed. During a follow up inspection (539120-0028) conducted on May 3, 2017, the requirements were confirmed to be outstanding and the licensee's bed rail use clinical assessment form and processes were determined to not be fully developed in accordance with the Clinical Guidance document identified above. Another CO was issued on May 30, 2017 with additional requirements to provide direct care staff training on bed safety, develop a bed safety policy and procedure, develop a

brochure or fact sheet for staff and families and to further amend their clinical bed rail use assessment form. The compliance due date was August 31, 2017. During this follow-up inspection, it was determined that several requirements were not complied with.

A) Policies and procedures were not fully developed (as required by #2 of the CO), and remained in draft format at the time of the inspection. The policies included some guidance for staff who were involved in evaluating bed systems for entrapment and staff who were involved in assessing the residents clinically for safe bed rail use. As the policies had not been completed, they could not be shared with all direct care staff as required by #3 of the CO.

B) The requirement to develop or acquire an information and education package/fact sheet/pamphlet that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario was not completed. The hand out or fact sheet was to include information regarding the risk factors that are considered high risk for bed system injury, suspension or entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use, the role of the Substitute Decision Maker and consents, how bed systems pass or fail entrapment zone testing and the contact information for Health Canada, Medical Devices Bureau for additional information and any bed system related injury, entrapment or suspension event. A brief fact sheet was developed for staff related to bed rail safety and handed out in September 2017, but the fact sheets had to be signed and handed back to the educator.

C) The requirement to amend and include on the resident bed rail use clinical assessment form appropriate "hard" bed rail alternatives for the resident was completed. The option of including soft rails (adjustable bolsters) was included along with dates they were started and ended. However, no space was allocated on the form to document who monitored the alternative, if it was effective or not during the specified trial time period and the reasons the alternative was or was not applied or trialled. The other "alternatives" that were listed on the form were considered interventions for falls risk such as bed alarm, increased monitoring, toileting schedule and falls mat, all of which are options that can be included with or without bed rails in place.

Five residents (#100, 101, 103, 104, 105) were randomly selected during this inspection to determine if they were assessed for bed safety risks. The RAI-MDS Coordinator, who had previously completed many of the assessments, reported that she counseled other registered staff to complete the clinical assessments. She developed a form titled

"Evaluation For Use of Bed Rails" (EFUBR) for use by herself and registered nurses to assess residents either upon admission, change in condition or at a specified frequency. The EFUBR form was amended to include several categories for completion including why bed rails were being considered, risk factors, medical symptoms (history of falls, pain, weakness, balance deficits, whether cognitive), sleep observation results (for three nights), bed mobility, alternatives trialled, type of bed rail being recommended, frequency for use and a section to be completed by the assessor titled "risk over benefit conclusion". The form included several safety risks for Personal Support Workers (PSW) to select from such as limbs through the bed rails, sleeping on or near edge of the bed, kicking or thrashing against the bed rails, positioning issues and involuntary body movements. Additional risks not included were slept with body parts on or against the bed rail, attempting to climb over the bed rail, whether the resident used the bed rail safely and whether the resident fell out of bed.

1. Resident #100 was observed in bed at the time of inspection, with both bed rails elevated. Their written plan of care included that the bed rails were to be applied for assistance with repositioning. The resident was assessed for bed rail use and safety in 2017. According to their EFUBR assessment, the resident was identified to have several risk factors that placed the resident at potential risk of bed rail related injury. Certain risk factors would require that bed rail alternatives be trialled before adding the "hard" bed rails onto a bed. During the resident's sleep observation period, both bed rails remained on the bed. The resident was able to use bed rails with staff assistance to turn side to side and to hold self to side. Otherwise the resident did not use their bed rails independently and had some limited mobility. The resident required repositioning by staff when in bed and could not transfer themselves out of bed.

At the end of the assessment, the assessor concluded that the resident was always found in a sleeping position that placed them at potential risk of a bed rail related injury. No risk over benefit summary was included. No recommendations were included to manage the identified risk factor that was observed.

The assessor concluded that the bed rails would remain in place due to "conditions identified on the front". The "front" was related to the answers on the front of the form, which included the above noted risk factors and a question related to why bed rails were being considered. The answers included "resident request" and "family request". For resident #100, family requested the bed rails for "safety" and "security". The assessment did not include what the terms "safety" or "security" meant. If bed rails were being applied for either safety or security, their use was in contradiction to the findings. In this

case, the bed rails appeared to have been more of a risk than a benefit and therefore an insufficient analysis was made to deem the bed rails as a device for "safety" purposes. According to the RAI MDS Coordinator, some families were very insistent that bed rails be applied, despite the risks being described to them. In this case, the assessment process was not completed in full, requiring the assessor to trial alternatives before making a final conclusion.

2. Resident #101 was observed in bed at the time of inspection, with both bed rails in a particular position. The resident was assessed for bed rail use and safety in 2017. According to their EFUBR assessment, the resident was identified to have several risk factors that placed the resident at potential risk of bed rail related injury. Such risk factors would require that bed rail alternatives be trialled before adding the "hard" bed rails onto a bed, which was not completed. During the resident's sleep observation period, no data boxes were checked off on the form and it was unknown whether the staff forgot to complete the form or no factors were identified. The PSWs who completed the form identified that the resident used the bed rail for repositioning. The risk over benefit conclusion did not offer any analysis of the resident's overall risks in using bed rails. The conclusion included a statement that the resident used the bed rail on one particular side as a positioning aid and that the bed would be maintained at a particular height with an additional accessory.

3. Resident #102 was not observed in bed during the inspection, but one bed rail was observed to be elevated on one side of the bed. The resident was interviewed about their bed rail use and stated that they used the bed rail for repositioning. They also showed the inspector a visible injury they had acquired from using the bed rails. They reported that both bed rails were applied when in bed. The Registered Nurse was aware of the injury and confirmed that the bed rails were the reason for the injury.

The resident was assessed for bed rail use and safety in 2017. According to their EFUBR assessment, the resident was identified to have very few risk factors that placed the resident at potential risk of bed rail related injury. During the resident's sleep observation period, many risk factors were identified. The resident's assessment included a note about specific night time behaviours and increased mobility. The PSWs documented that they felt the resident needed both bed rails elevated because of the observations they made. No injury was documented during the sleep observation at that time and the RAI-MDS Coordinator stated that the resident's clinical record did not include any injuries. The alternatives section of the EFUBR form was blank. The risk over benefit conclusion did not offer a sufficient analysis of the resident's overall risks in

having the bed rail applied. The conclusion was limited and included a statement that the resident was able to transfer in and out of bed on one side and that they used one bed rail on the other side to aid in positioning and bed mobility. No interventions were applied to minimize the identified injury and the intervention was not included in the resident's written plan of care. An accessory was applied during the inspection after the inspector discussed the concerns with the Director of Care.

4. Resident #104 was observed during the inspection, with one bed rail elevated. The most recent EFUBR assessment could not be located in the resident's chart, but according to the RAI MDS Coordinator, the resident was assessed for bed rail use and safety in 2017. According to the Coordinator, the resident had several risk factors that placed the resident at potential risk of bed rail related injury. The resident did not get out of bed during the sleep observation period and required one bed rail as a positioning aid. The resident was confirmed to be able to hold onto the bed rail to turn self and liked to have it for a sense of security. The resident had a history of falls and interventions were added but no alternatives to the bed rail were listed as trialled. However, the Coordinator recalled that a specified alternative was trialled in the past, but was not effective.

Their written plan of care included that the resident required two staff to assist the resident for bed mobility and that the resident needed to be encouraged to grab onto the bed rail while staff assist to turn them over. The PSWs did not select any of the check boxes on the form under "risk factors" and it is unknown if they forgot to check off any boxes or that no risks were identified. The risk over benefit conclusion did not offer a sufficient analysis of the resident's overall risks in having the bed rail applied. The conclusion was limited and included a statement that the resident used the bed rail for positioning and bed mobility.

5. Resident #105 was observed in bed at the time of inspection, in a precarious position and was interacting with a mobility device. Their bed rail was elevated on one side. Specific falls intervention devices were in place. When the mobility device was removed, the resident continued to try and interact with it. The RPN was informed about the resident and after checking on the resident, stated that the behaviour was well known to them. On an identified date in 2017, RAI MDS Coordinator reported that the resident had sustained a fall.

The resident was assessed for bed rail use and safety in 2017. According to their EFUBR assessment, the resident had several risk factors that placed the resident at potential risk of bed rail related injury (i.e. medical symptoms, cognition deficits, falls history, physical

condition and emotional status). The cognition section of the form was blank but their clinical record identified the resident with cognitive issues.

The residents sleep observation included that the resident attempted to get out of bed independently, was able to use their bed rails independently and slept soundly at night without any concerns. The form also included that the bed rail was used to avoid rolling out of bed and that the resident required assistance with bed mobility. The observation made at the time of inspection, did not correlate with the documented finding, as the resident appeared capable of independent bed mobility and was at risk of falling or having a limb or body part becoming entrapped within the elevated bed rail.

The assessor concluded that the bed rails would remain in place due to "conditions identified on the front". The "front" was related to the answers on the front of the form, which included the above noted risk factors and a question related to why bed rails were being considered. The answers included "resident request" and "family request". For resident #105, family requested the bed rails for "safety" and "security". The assessment did not include what the terms "safety" or "security" meant. If bed rails were being applied for either safety or security, their use was in contradiction to the findings. In this case, the bed rails appeared to have been more of a risk than a benefit and therefore an insufficient analysis was made to deem the bed rails as a device for "safety" purposes. In this case, the assessment process was not completed in full, requiring the assessor to trial alternatives before making a final conclusion. No alternatives were trialled to replace the "hard" bed rail that was observed in place. No strategies were documented to prevent the resident from interacting with mobility devices. The risk over benefit conclusion did not offer a sufficient analysis of the resident's overall risks in having the bed rail applied. The conclusion was limited and included a brief statement as to why the resident needed the bed rails.

Questions posed to the RAI MDS Coordinator included whether the resident needed a bed rail for bed mobility, considering their observed behaviours and level of mobility. Their written plan of care included that the resident required turning and repositioning at particular frequencies when awake. It was unclear whether the resident could turn side to side independently by using their bed rail without staff assistance. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 16th day of January, 2018

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

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

Ministére 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

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0067
Log No. / No de registre :	011035-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 15, 2018
Licensee / Titulaire de permis :	Maplewood Nursing Home Limited 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
LTC Home / Foyer de SLD :	Cedarwood Village 500 Queensway West, SIMCOE, ON, N3Y-4R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Hastings

To Maplewood Nursing Home Limited, 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_539120_0028, 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 :

The licensee shall complete the following:

1. Finalize bed safety related policies and procedures and provide guidance for staff who are involved in evaluating bed systems for entrapment and staff who are involved in assessing the residents clinically for safe bed rail use. The prevailing practices known as the "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 Health Canada's guidelines titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008”, shall be used as reference material in developing the policies and procedures. At a minimum the policy shall include;

a) alternatives that are available for the replacement of bed rails and the process of trialling the alternatives and documenting their use; and
b) what interventions are available to mitigate any identified bed safety entrapment, suspension or injury risks; and
c) the role of the SDM and/or resident in selecting the appropriate personal assistance services device for the resident’s unique identified care needs; and

d) the role of and responsibilities of personal support workers with respect to observing residents in bed related to their bed systems (which includes bed rails, bed frame, accessories, mattresses, bed remote control) and associated safety hazards; and
e) the role of the registered staff in analyzing the collected data and weighing the risks over the benefits of bed rail use and documenting the decision.

2. Upon completion of the policies and procedures, all direct care staff (RNs, RPNs, PSWs) shall receive face to face instruction on the contents of the policies and procedures and associated forms and a record shall be kept of those who participated and the dates attended.

3. Develop or acquire an information and education package/fact sheet/pamphlet that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario. The hand out or fact sheet shall include information regarding the risk factors that are considered high risk for bed system injury, suspension or entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use, the role of the Substitute Decision Maker and consents, how bed systems pass or fail entrapment zone testing and the contact information for Health Canada, Medical Devices Bureau for additional information and any bed system related injury, entrapment or suspension event.

4. The "Evaluation for Use of Bed Rails" form shall be amended to include space to document why alternatives to using bed rails were not trialled (if not applicable) and what the outcome of the alternative was, whether successful or not for the resident.

Grounds / Motifs :

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

A companion guide 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) provides the necessary guidance in establishing a clinical assessment where bed rails are used. It is cited in a guidance document developed by Health Canada titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch

Reliability and Other Hazards, March 2008" and was identified by the Ministry of Health and Long Term Care in 2012, as the prevailing practice.

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A) Policies and procedures were not fully developed (as required by #2 of the CO), and remained in draft format at the time of the inspection. The policies included some guidance for staff who were involved in evaluating bed systems for entrapment and staff who were involved in assessing the residents clinically for safe bed rail use. As the policies had not been completed, they could not be shared with all direct care staff as required by #3 of the CO.

B) The requirement to develop or acquire an information and education package/fact sheet/pamphlet that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario was not completed. The hand out or fact sheet was to include information regarding the risk factors that are considered high risk for bed system injury, suspension or entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use, the role of the Substitute Decision Maker and consents, how bed systems pass or fail entrapment zone testing and the contact information for Health Canada, Medical Devices Bureau for additional information and any bed system related injury, entrapment or

suspension event. A brief fact sheet was developed for staff related to bed rail safety and handed out in September 2017, but the fact sheets had to be signed and handed back to the educator.

C) The requirement to amend and include on the resident bed rail use clinical assessment form appropriate “hard” bed rail alternatives for the resident was completed. The option of including soft rails (adjustable bolsters) was included along with dates they were started and ended. However, no space was allocated on the form to document who monitored the alternative, if it was effective or not during the specified trial time period and the reasons the alternative was or was not applied or trialled. The other “alternatives” that were listed on the form were considered interventions for falls risk such as bed alarm, increased monitoring, toileting schedule and falls mat, all of which are options that can be included with or without bed rails in place.

Five residents (#100, 101, 103, 104, 105) were randomly selected during this inspection to determine if they were assessed for bed safety risks. The RAI-MDS Coordinator, who had previously completed many of the assessments, reported that she counseled other registered staff to complete the clinical assessments. She developed a form titled "Evaluation For Use of Bed Rails" (EFUBR) for use by herself and registered nurses to assess residents either upon admission, change in condition or at a specified frequency. The EFUBR form was amended to include several categories for completion including why bed rails were being considered, risk factors, medical symptoms (history of falls, pain, weakness, balance deficits, whether cognitive), sleep observation results (for three nights), bed mobility, alternatives trialled, type of bed rail being recommended, frequency for use and a section to be completed by the assessor titled “risk over benefit conclusion”. The form included several safety risks for Personal Support Workers (PSW) to select from such as limbs through the bed rails, sleeping on or near edge of the bed, kicking or thrashing against the bed rails, positioning issues and involuntary body movements. Additional risks not included were slept with body parts on or against the bed rail, attempting to climb over the bed rail, whether the resident used the bed rail safely and whether the resident fell out of bed.

1. Resident #100 was observed in bed at the time of inspection, with both bed rails elevated. Their written plan of care included that the bed rails were to be applied for assistance with repositioning. The resident was assessed for bed rail use and safety in 2017. According to their EFUBR assessment, the resident

was identified to have several risk factors that placed the resident at potential risk of bed rail related injury. Certain risk factors would require that bed rail alternatives be trialled before adding the "hard" bed rails onto a bed. During the resident's sleep observation period, both bed rails remained on the bed. The resident was able to use bed rails with staff assistance to turn side to side and to hold self to side. Otherwise the resident did not use their bed rails independently and had some limited mobility. The resident required repositioning by staff when in bed and could not transfer themselves out of bed.

At the end of the assessment, the assessor concluded that the resident was always found in a sleeping position that placed them at potential risk of a bed rail related injury. No risk over benefit summary was included. No recommendations were included to manage the identified risk factor that was observed.

The assessor concluded that the bed rails would remain in place due to "conditions identified on the front". The "front" was related to the answers on the front of the form, which included the above noted risk factors and a question related to why bed rails were being considered. The answers included "resident request" and "family request". For resident #100, family requested the bed rails for "safety" and "security". The assessment did not include what the terms "safety" or "security" meant. If bed rails were being applied for either safety or security, their use was in contradiction to the findings. In this case, the bed rails appeared to have been more of a risk than a benefit and therefore an insufficient analysis was made to deem the bed rails as a device for "safety" purposes. According to the RAI MDS Coordinator, some families were very insistent that bed rails be applied, despite the risks being described to them. In this case, the assessment process was not completed in full, requiring the assessor to trial alternatives before making a final conclusion.

2. Resident #101 was observed in bed at the time of inspection, with both bed rails in a particular position. The resident was assessed for bed rail use and safety in 2017. According to their EFUBR assessment, the resident was identified to have several risk factors that placed the resident at potential risk of bed rail related injury. Such risk factors would require that bed rail alternatives be trialled before adding the "hard" bed rails onto a bed, which was not completed. During the resident's sleep observation period, no data boxes were checked off on the form and it was unknown whether the staff forgot to complete

the form or no factors were identified. The PSWs who completed the form identified that the resident used the bed rail for repositioning. The risk over benefit conclusion did not offer any analysis of the resident's overall risks in using bed rails. The conclusion included a statement that the resident used the bed rail on one particular side as a positioning aid and that the bed would be maintained at a particular height with an additional accessory.

3. Resident #102 was not observed in bed during the inspection, but one bed rail was observed to be elevated on one side of the bed. The resident was interviewed about their bed rail use and stated that they used the bed rail for repositioning. They also showed the inspector a visible injury they had acquired from using the bed rails. They reported that both bed rails were applied when in bed. The Registered Nurse was aware of the injury and confirmed that the bed rails were the reason for the injury.

The resident was assessed for bed rail use and safety in 2017. According to their EFUBR assessment, the resident was identified to have very few risk factors that placed the resident at potential risk of bed rail related injury. During the resident's sleep observation period, many risk factors were identified. The resident's assessment included a note about specific night time behaviours and increased mobility. The PSWs documented that they felt the resident needed both bed rails elevated because of the observations they made. No injury was documented during the sleep observation at that time and the RAI-MDS Coordinator stated that the resident's clinical record did not include any injuries. The alternatives section of the EFUBR form was blank. The risk over benefit conclusion did not offer a sufficient analysis of the resident's overall risks in having the bed rail applied. The conclusion was limited and included a statement that the resident was able to transfer in and out of bed on one side and that they used one bed rail on the other side to aid in positioning and bed mobility. No interventions were applied to minimize the identified injury and the intervention was not included in the resident's written plan of care. An accessory was applied during the inspection after the inspector discussed the concerns with the Director of Care.

4. Resident #104 was observed during the inspection, with one bed rail elevated. The most recent EFUBR assessment could not be located in the resident's chart, but according to the RAI MDS Coordinator, the resident was assessed for bed rail use and safety in 2017. According to the Coordinator, the resident had several risk factors that placed the resident at potential risk of bed rail related

injury. The resident did not get out of bed during the sleep observation period and required one bed rail as a positioning aid. The resident was confirmed to be able to hold onto the bed rail to turn self and liked to have it for a sense of security. The resident had a history of falls and interventions were added but no alternatives to the bed rail were listed as trialled. However, the Coordinator recalled that a specified alternative was trialled in the past, but was not effective.

Their written plan of care included that the resident required two staff to assist the resident for bed mobility and that the resident needed to be encouraged to grab onto the bed rail while staff assist to turn them over. The PSWs did not select any of the check boxes on the form under "risk factors" and it is unknown if they forgot to check off any boxes or that no risks were identified. The risk over benefit conclusion did not offer a sufficient analysis of the resident's overall risks in having the bed rail applied. The conclusion was limited and included a statement that the resident used the bed rail for positioning and bed mobility.

5. Resident #105 was observed in bed at the time of inspection, in a precarious position and was interacting with a mobility device. Their bed rail was elevated on one side. Specific falls intervention devices were in place. When the mobility device was removed, the resident continued to try and interact with it. The RPN was informed about the resident and after checking on the resident, stated that the behaviour was well known to them. On an identified date in 2017, RAI MDS Coordinator reported that the resident had sustained a fall.

The resident was assessed for bed rail use and safety in 2017. According to their EFUBR assessment, the resident had several risk factors that placed the resident at potential risk of bed rail related injury (i.e. medical symptoms, cognition deficits, falls history, physical condition and emotional status). The cognition section of the form was blank but their clinical record identified the resident with cognitive issues.

The residents sleep observation included that the resident attempted to get out of bed independently, was able to use their bed rails independently and slept soundly at night without any concerns. The form also included that the bed rail was used to avoid rolling out of bed and that the resident required assistance with bed mobility. The observation made at the time of inspection, did not correlate with the documented finding, as the resident appeared capable of independent bed mobility and was at risk of falling or having a limb or body part

becoming entrapped within the elevated bed rail.

The assessor concluded that the bed rails would remain in place due to "conditions identified on the front". The "front" was related to the answers on the front of the form, which included the above noted risk factors and a question related to why bed rails were being considered. The answers included "resident request" and "family request". For resident #105, family requested the bed rails for "safety" and "security". The assessment did not include what the terms "safety" or "security" meant. If bed rails were being applied for either safety or security, their use was in contradiction to the findings. In this case, the bed rails appeared to have been more of a risk than a benefit and therefore an insufficient analysis was made to deem the bed rails as a device for "safety" purposes. In this case, the assessment process was not completed in full, requiring the assessor to trial alternatives before making a final conclusion. No alternatives were trialled to replace the "hard" bed rail that was observed in place. No strategies were documented to prevent the resident from interacting with mobility devices. The risk over benefit conclusion did not offer a sufficient analysis of the resident's overall risks in having the bed rail applied. The conclusion was limited and included a brief statement as to why the resident needed the bed rails.

Questions posed to the RAI MDS Coordinator included whether the resident needed a bed rail for bed mobility, considering their observed behaviours and level of mobility. Their written plan of care included that the resident required turning and repositioning at particular frequencies when awake. It was unclear whether the resident could turn side to side independently by using their bed rail without staff assistance.

This Compliance Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. In respect to severity, there is potential for actual harm (2), for scope, the number of residents who have not been adequately assessed is widespread (3) and previous non-compliance (4) related to bed safety was issued as a Compliance Order under the same section on February 23, 2016 and May 30, 2017. (120)

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

Ministére 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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 31, 2018

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

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 15th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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