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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119 King Street West 11th Floor
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119 rue King Ouest 11iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 21, 2016	2016_189120_0060	008564-16	Follow up

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HAMILTON
90 CHEDMAC DRIVE HAMILTON ON L9C 7S6

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): September 28, 2016

An inspection (2015-337581-0014) was previously conducted July 18 - August 17, 2015 at which time non-compliance was issued related to bed safety in the form of an Order (#003). A follow-up was conducted on March 2, 2016 and the Order was determined to remain outstanding. For this follow-up inspection, the Order was not fully complied with and remains outstanding. See below for details.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, RAI-MDS co-ordinators, environmental manager and personal support workers (PSW).

During the course of the inspection, the inspector toured the 2nd floor of the home (which included 3 home areas), observed the home's bed systems, reviewed staff education materials regarding bed safety and attendance records, residents' care plans and clinical assessments and the home's bed rail policy.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources".

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents 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 are made that all residents who use one or more bed rails 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. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in

bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to who participated in the decision-making, whether bed rails would be indicated or not, alternatives trialled, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A) The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above noted Clinical Guidance document. A key requirement laid out in both previous Orders issued on September 1, 2015 and March 2, 2016, required that the licensee develop or amend their existing clinical bed rail use questionnaires and decision making documents to include additional questions (and guidance) related to risks associated with bed rail use as identified in the above noted Clinical Guidance document. Each resident was to be re-assessed using the amended forms and documents. According to the forms provided during the inspection, no changes were evident from the forms used in March 2016. According to the Administrator, who provided copies of educational materials used to train registered staff regarding bed safety since March 2, 2016, direction was given to use a form titled "Bed Rail Risk Assessment" to conduct the clinical assessments of all residents. Confirmation was also made on October 6, 2016 with the licensee's corporate nursing consultant that the licensee did not use the correct form when they completed the resident clinical assessments for bed safety after March 2, 2016. According to the consultant, a form titled "Bedrail and Entrapment Risk Assessment" was developed and was to be implemented. A review of this form revealed that it included many more questions related to bed safety risks and had additional sections for decision making but did not include whether the resident was observed

independently in bed for sleeping habits and for how many nights and by whom.

According to two registered staff members who completed resident bed rail use assessments over the last five months, the form that was used was titled "PASD (Personal assistance serviced device) – V2". The completed forms were provided for review of six randomly selected residents. The assessors reported that newly admitted residents were first assessed without a bed rail. If after a period of time, the resident was assessed as requiring assistance with bed mobility or transfers, one or both bed rails were applied. Residents who were already in the home and who already had one or more bed rails in use after March 2016, were re-assessed. The information regarding bed rail use was included and confirmed to be in the residents' plan of care for direction to staff. According to the two assessors, the registered staff and Personal Support Workers (PSWs) contributed information related to a resident's ability to use a bed rail safely and considered risks such as physical injury, strangulation, suspension or the habit of trying to climb over the bed rails over the course of several nights. However, the home's draft policy titled "Use of Bedrail Devices" dated April 2011 related to bed rails did not include any written procedures for staff guidance which clearly identified which form to use and did not reference the above noted Clinical Guidance document. Neither the form or the policy included information regarding if/how long residents were to be observed, the dates that they were observed and the specific behaviours that were to be monitored during the observation period, did not include any guidance or questions related to the various risk factors associated with bed rail use (that could potentially cause bed rail injury, entrapment or death), what the assessors would need to consider before applying them (alternatives trialled) and any monitoring programs needed to ensure that all staff apply bed rails as assessed.

B) During a tour of the second floor, six residents were randomly selected to have their plan of care reviewed related to their bed rail use and whether bed rail associated risk assessments were conducted and results documented.

Two out of the six residents were in bed at the time of observation. Resident #101 had one rotating assist bed rail in the guard position on their right and resident #102 had both 3/4 length rails elevated. The other residents were not in bed, but each of their beds had at least one rotating assist rail in the guard position. The plan of care for all six residents reflected that they each required one or both bed rails for bed mobility (whether for transfers and/or repositioning/turning). For five of the residents whose beds were equipped with rotating assist rails, the plans did not include what position their bed rails should be in, whether in the guard position or in the transfer or assist position while in

bed or otherwise.

Six out of the six clinical bed safety assessments (titled PASD - V2) did not include any written questions related to whether the residents' bed rail(s) presented a possible risk associated with their assessed condition or whether the resident was observed, for how long and what conditions were considered during the observation period to determine whether the bed rails were a safe option for the resident. The questions noted on the form were limited to the resident's cognitive status and their physical limitations.

According to the licensee, 50% of residents continue to use one or more bed rails in the home and that bed rail use dropped by approximately 50% after bed rail use assessments were conducted after March 2016.

C) Six out of the six clinical bed safety assessments (titled PASD-V2) did not include what bed rail alternatives were trialled before the bed rails were applied to minimize or eliminate the possible risks associated with strangulation, suspension, entrapment, entanglement, injuries, skin tears or bruising. Bed rail alternatives or measures to mitigate risks are included in the Clinical Guidance document and the include a wide variety of methods and substitutions for bed rail dependency which include medical, physical and cognitive interventions. Examples include transfer pole, bed rail guards or padding, height adjustable bed, bed alarms, raised perimeter mattress (easier to grab than a flat mattress when being repositioned), adjustable bolsters (also known as soft rails) or teaching the resident new transfer or re-positioning techniques. The alternatives available on the home's PASD form included "improved lighting, increased supervision, prompting during the completion of the ADL, re-enforcement/teaching of technique/method of completing ADL, noise reduction, pain management, adaptive aides and height adjustable dining room table. For all six residents reviewed, the option for "adaptive aides" was checked off. No explanation was available regarding what type of adaptive aid was trialled, when, for how long and whether it was a successful intervention or not.

This Order is based upon the above non-compliance and 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. The severity is 2 (potential for harm), the scope is 3 (wide spread -all of the residents have not been assessed in accordance with prevailing practices) and the compliance history is 3 (non-compliance previously issued in the same area). An Order was previously issued on September 1, 2015 and March 2, 2016. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 21st day of October, 2016

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2016_189120_0060
Log No. / Registre no:	008564-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 21, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE HAMILTON 90 CHEDMAC DRIVE, HAMILTON, ON, L9C-7S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pilar Henderson

To EXTENDICARE (CANADA) INC., 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: 2016_189120_0011, CO #001;

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing forms or create a new form to include all relevant questions and 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) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form and document the assessed results and recommendations for each resident.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.

4. Amend the existing "Use of Bedrail Devices" policy to include procedures that will guide an assessor in completing a clinical bed safety assessment in accordance with the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" document.

Grounds / Motifs :

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

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources".

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required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A) The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above noted Clinical Guidance document. A key requirement laid out in both previous Orders issued on September 1, 2015 and March 2, 2016, required that the licensee develop or amend their existing clinical bed rail use questionnaires and decision making documents to include additional questions (and guidance) related to risks associated with bed rail use as identified in the above noted Clinical Guidance document. Each resident was to be re-assessed using the amended forms and documents. According to the forms provided during the inspection, no changes were evident from the forms used in March 2016. According to the Administrator, who provided copies of educational materials used to train registered staff regarding bed safety since March 2, 2016, direction was given to use a form titled "Bed Rail Risk Assessment" to conduct the clinical assessments of all residents. Confirmation was also made on October 6, 2016 with the licensee's corporate nursing consultant that the licensee did not use the correct form when they completed the resident clinical assessments for bed safety after March 2, 2016. According to the consultant, a form titled "Bedrail and Entrapment Risk Assessment" was developed and was to be implemented. A review of this form revealed that it included many more questions related to bed safety risks and had additional sections for decision making but did not include whether the resident was observed independently in bed for sleeping habits and for how many nights and by whom.

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Workers (PSWs) contributed information related to a resident's ability to use a bed rail safely and considered risks such as physical injury, strangulation, suspension or the habit of trying to climb over the bed rails over the course of several nights. However, the home's draft policy titled "Use of Bedrail Devices" dated April 2011 related to bed rails did not include any written procedures for staff guidance which clearly identified which form to use and did not reference the above noted Clinical Guidance document. Neither the form or the policy included information regarding if/how long residents were to be observed, the dates that they were observed and the specific behaviours that were to be monitored during the observation period, did not include any guidance or questions related to the various risk factors associated with bed rail use (that could potentially cause bed rail injury, entrapment or death), what the assessors would need to consider before applying them (alternatives trialled) and any monitoring programs needed to ensure that all staff apply bed rails as assessed.

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Six out of the six clinical bed safety assessments (titled PASD - V2) did not include any written questions related to whether the residents' bed rail(s) presented a possible risk associated with their assessed condition or whether the resident was observed, for how long and what conditions were considered during the observation period to determine whether the bed rails were a safe option for the resident. The questions noted on the form were limited to the resident's cognitive status and their physical limitations.

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This Order is based upon the above non-compliance and 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. The severity is 2 (potential for harm), the scope is 3 (wide spread -all of the residents have not been assessed in accordance with prevailing practices) and the compliance history is 3 (non-compliance previously issued in the same area). An Order was previously issued on September 1, 2015 and March 2, 2016. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

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

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of October, 2016

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