Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 22, 2020	2020_556168_0007	017384-19, 020503-19	Follow up

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
5290 Yonge Street Suite 200 NORTH YORK ON M2N 5P9

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

Hardy Terrace
612 Mount Pleasant Road, R.R. #2 BRANTFORD ON N3T 5L5

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

LISA VINK (168)

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): February 25, 26, 27, 28, 2020 and March 2, 2020.

Long-Term Care Homes Consultant / Environmental Health Inspector Bernadette Susnik, participated in this inspection on February 25 and 26, 2020.

This Follow Up inspection was conducted related to:
Log 020503-19 for follow up to Compliance Order (CO) #001 from inspection number 2019 556168-0019 for Ontario Regulation (O. Reg) 79/10 section (s.) 8(1)b for policies, etc., to be followed, and records, with a Compliance Due Date (CDD) of January 31, 2020; and
Log 017384-19 for follow up to CO #001 from inspection number 2019 541169-0015 (A1) for O. Reg. 79/10 s. 15(1) related to bed rails with a CDD of December 31, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the associate DOC, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), the maintenance supervisor and residents.

During the course of the inspection, the inspectors observed the provision of care and services, evaluated lighting levels, toured the home, and reviewed documents including but not limited to: training records, relevant policies and procedures, bed entrapment testing and clinical health records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2019_556168_0019	168

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 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 failed to ensure that where bed rails were used, five identified residents were assessed in accordance with prevailing practices, to minimize risk to the residents.

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.
The guide is cited in a document developed by Health Canada titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards”, March 2008.
The Health Canada guide was identified by the Director of the Ministry of Long Term Care in 2012 and 2019, as the prevailing practice with respect to bed safety.
According to the Clinical Guidance document, “in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape”. Once an interdisciplinary team has initially assessed a resident for their ability to use bed rails, and deemed them to be beneficial to the resident in their bed mobility activities, residents need to undergo additional monitoring for safety hazards. Residents need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk-related hazards associated with the application of one or more bed rails.
The Clinical Guidance document emphasizes the importance of establishing procedures

and processes for bed safety monitoring. Monitoring includes but is not limited to who would monitor the residents, for how long and at what frequency, the specific hazards that would need to be monitored for while the resident is in bed with one or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails are available and trialled before the application of bed rails.

For this Follow-Up inspection, a Compliance Order (CO) that was previously issued on November 4, 2019, report number 2019-541169-0015 (A1), was reviewed to determine compliance. The CO directed the licensee to complete specific requirements to achieve compliance, those that were not complied with are listed below.

The Administrator reported that they had reviewed the clinical guidance documents and developed a program for bed safety. This program included a policy and procedure titled "Safe Use of Bed Rails", effective December 2, 2019, a Sleep Observation Record, a Bed Rail Utilization Quarterly Assessment, information for residents and family members related to bed rails, education for registered nursing staff and an auditing component.

A review of the policy and procedure "Safe Use of Bed Rails", effective December 2, 2019, with the Administrator, confirmed that the document, did not include, as previously required:
i. An assessment that required clear documentation of the alternatives that were trialled prior to the application of one of more bed rails and whether or not the alternatives were effective during the specified period of use or if no alternatives were trailed why, nor the names of the team members who participated in the assessment;
ii. The role of the PSW in monitoring residents while in bed, with bed rails applied, and the safety risks that they were to monitor for;
iii. The Substitute Decision Maker's role in making decisions about the application of bed rails;
iv. The process for recognizing and reporting bed system deficiencies and the process for reporting bed system changes to management staff; nor
v. The names of the documents and references used to develop the policy.

The Administrator identified that direction was provided to nursing staff to complete a Sleep Observation Record on all new residents and that other residents in the home, who already utilized bed rails would be assessed into the first quarter of 2020. Additionally direction was provided that if it was suspected that a resident no longer required the use of bed rail(s), staff were to complete a Sleep Observation Record, to assist in decision making regarding the safety and use of bed rails.

Interview with RN #105 and RPN #106 both indicated that to their knowledge currently only new admissions were assessed, using the Sleep Observation Record, not residents, previously residing in the home who utilized bed rails.

Information was provided to residents and families which included: a presentation at a Town Hall Meeting by the Administrator to discuss bed rails; the posting of a Bed Rail Fact Sheet in accessible locations in the home and a mail out pamphlet titled "A Guide to Bed Safety" created by the home.
On review of the information provided, it did not include the previously required information regarding: identification of the regulations and prevailing practices governing adult hospital beds in Ontario; how beds were assessed to determine if they passed or failed entrapment zone testing; nor the role of the Substitute Decision Maker in relation to bed rail use, as confirmed by the Administrator following a review of the documents.

RN #105 and RPNs #106 and #104 identified that they were responsible to complete bed rail risk assessments on residents but were not familiar with the prevailing practice documents “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" or “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards”. The registered staff confirmed that they had recently received training regarding the new policy and procedure and assessments to be completed; however, the training did not clearly include zones of entrapment, assessment of gaps, regulatory requirements in Ontario regarding adult hospital beds etc. as previously required.

RN #101 confirmed that they provided training to all registered staff regarding of the policy and procedure “Safe Use of Bed Rails” starting in December 2019; however, confirmed that they only provided training to registered nursing staff.
Interview with the Administrator confirmed that information was not provided to all non-registered staff regarding the bed safety procedure nor face to face education about bed system hazards (zones of entrapment and other injuries), regulatory requirements in Ontario regarding adult hospital beds, the risk and benefits of bed rail use, resident risk factors associated with increased risk of injury related to bed rail use, how to identify and report bed system deficiencies and any other relevant information identified in the prevailing practices, as previously required.

2. Residents who utilized bed rails were observed and their clinical records were reviewed:
i. Resident #011 was observed in bed, on an identified date in February 2020, with one

or more bed rails applied, which was consistent with the directions in their plan of care. Interview with the resident confirmed the use of the bed rails as per the plan. A review of the clinical record did not include a completed Sleep Observation Record nor a Bed Rail Utilization Quarterly Assessment, as confirmed by RPN #106.
ii. Resident #020 was observed in bed, on an identified date in February 2020, with one or more bed rails applied, which was consistent with the directions in their plan of care. A review of the clinical record did not include a completed Sleep Observation Record as confirmed by RN #105, following a review of the clinical record.
iii. Resident #017 confirmed the use of one or more bed rails when in bed, which was consistent with the directions in their plan of care. A review of the clinical record did not include a completed Sleep Observation Record nor a Bed Rail Utilization Quarterly Assessment, as confirmed by RPN #106.
iv. Resident #015 confirmed the use of one or more bed rails when in bed, which was consistent with the directions in their plan of care. A review of the clinical record did not include a completed Sleep Observation Record nor a Bed Rail Utilization Quarterly Assessment, as confirmed by RPN #106.
v. Resident #019 was observed in bed, on an identified date in February 2020, with one or more bed rails applied, which was consistent with the directions in their plan of care. A review of the clinical record did not include a completed Sleep Observation Record nor a Bed Rail Utilization Quarterly Assessment, as confirmed by RPN #106.
The five residents were not reassessed, since the previous inspection, as to whether alternatives to bed rails were trialled, the records did not include any current information about the residents' sleep behaviours and whether any risks were observed while sleeping in bed with bed rails applied. The risk over benefit of applying bed rails for resident use was not documented.

The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

1. The licensee failed to ensure that where bed rails were used, by four residents, that other safety issues related to the use of bed rails were addressed.

i. The bed system of resident #019 was observed on an identified date in February 2020. It was noted that the bed frame was equipped with bed rails. The bed rails were noted to be loose and moved back and forth with little effort. The resident was observed in bed on an identified date in February 2020, with one or more bed rails in the raised position. When tested the bed rails remained loose.

ii. The bed system of resident #016 was observed on an identified date in February 2020. It was noted that the bed frame was equipped with bed rails. When assessed one bed rail was noted to be loose and moved back and forth with little effort when positioned in raised positions. Interview with the resident confirmed that they used the bed rail when in bed.
On an identified date in February 2020, PSW #103 confirmed that the resident used the bed rail when in bed and in their opinion the bed rail was not loose.
iii. The bed system of resident #017 was observed on an identified date in February 2020. It was noted that the bed frame was equipped with bed rails. The bed rails were noted to be loose and moved back and forth with little effort. Interview with the resident confirmed that they used the bed rails when in bed.
iv. The bed system of resident #020 was observed on an identified date in February 2020. It was noted that the bed frame was equipped with bed rails. A bed rail was noted to be loose and moved back and forth with little effort. The resident was observed in bed on an identified date in February 2020, with one or more bed rails in a raised position. When tested the rail remained loose.

On an identified date in February 2020, PSW #107 observed the bed rails utilized by resident #017 and PSW #108 observed the bed rails utilized by resident's #016, #019 and #020. Both PSWs confirmed, on movement of the bed rails and demonstration of the inspector, that one or more bed rails on each bed was loose.
A discussion was held with the Maintenance Supervisor regarding bed rails. They identified awareness of the potential for the bed rails to become loosened over time with use. The condition of the identified bed rails were discussed and all but one of the bed rails were tightened the same day, with the last bed rail tightened at a later date.

Discussion with the Administrator identified a plan to provide additional training to staff regarding bed rails and the safe use of, as well as to include bed rails and a schedule for preventative maintenance of bed rails into their Maintenance Care software program. [s. 15. (1) (c)]

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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

The licensee failed to ensure that lighting requirements set out in the lighting table were maintained in resident bedrooms and washrooms located in wings A, B, C and D.

The home was configured with four wings, located on the north, east and south side of the building (A, B, C and D) built prior to 2002 and two wings on the west side (E and F) built in 2002. Therefore, the section of the lighting table that was applied was entitled "In all other areas of the home". A hand held analogue light meter was used (Sekonic Handi Lumi) to measure the lux levels in one private, two semi private and a four-bed resident room and associated ensuite washrooms located in the older side of the building.

The light meter that was used was calibrated before use and held at a standard 30 inches above and parallel to the floor. Window coverings were drawn in the resident bedrooms being measured, bedroom doors were closed and all lights were turned on within the rooms, including overbed lights. The minimum required lux for all resident areas is 215.28 lux (bedrooms, washrooms, lounges, etc.) and 376.73 lux at the head of the bed when in the reading position. The areas specifically measured included areas in the bedrooms and washrooms where activities of daily living occurred such as toileting, dressing, personal hygiene, reading and care at bedside.

i. Two semi-private bedrooms were measured and were equipped with the same type and number of light fixtures as in all of the other semi-private rooms on the north, east and south side. The identified rooms had a wall mounted reading light located above each bed consisting of two fluorescent type light bulbs (one upper and one lower). The reading lights were both above the minimum requirement of 376.73 lux. Two ceiling mounted dome lights with opaque lens were situated along the length of the rooms, positioned near the foot of each bed. One was in front of a closet for bed one and another at the foot of the bed for bed two (by window) in both rooms. The bed near the washroom was measured in both rooms. In an identified room, 200 lux was measured at the side of bed, 110 lux at the foot of the bed, and 180 lux near the closet and under the fixture. In another identified room, at the entrance of the room was 100 lux, near the closet was 180 lux, at the side of the bed was 220 lux, and at the foot of the bed was 110 lux. Both washrooms had the same wall mounted fixture with two bulbs and an opaque fixture lens. For the first room, it was 175 lux at the sink and 50 lux at the toilet. For the washroom in the second room, the lux was 100 at the sink and 80 lux at the toilet.
ii. A private bedroom was measured and was equipped with the same number and type of light fixtures as in all of the other private rooms on the east, north and south side. There were no ceiling lights in the room with the exception of a ceiling mounted dome light with opaque lens at the entrance. The lux was 105 under the light. The route towards the bed was 100 lux, 110 lux at the side of bed, and 90 lux at the foot of the bed. The reading light was compliant. The same light fixture was noted in the washroom as in other rooms evaluated. The lux at the sink was compliant at 310 lux, but not at the toilet which was 180 lux.
iii. A four-bed room was measured and was equipped with the same number and type of light fixtures as in all of the other four-bed rooms. There were no ceiling lights provided in the bedroom except for at the entrance and in the alcove with resident built in closets. The lux at the entrance was 180, the path to the bed was 120 lux, foot of the bed was 100 lux, closet area was 175 lux and the side of the bed was 230 lux. The reading light was compliant. The washroom fixture provided was the same as in the other

washrooms. The lux at the sink was 175 and 50 lux at the toilet.

The Maintenance Supervisor was aware of the lower light levels in the older section of the building (compared to the west side) but did not know the exact levels. They reported that many of the older model fluorescent tube bulbs were being replaced with LED bulbs, which were brighter. [s. 18.]

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 lighting requirements set out in the Table of this section were maintained, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

The licensee failed to ensure that the home and equipment were maintained in a good state of repair, in the main dining room and tub rooms.

i. On an identified date in February 2020, the main dining room was observed to have an area with cabinetry and two sinks.
The single lever faucet on the hand sink was corroded at the base and could be moved side to side.
The shelf under the second sink was made of exposed press board and was warped. It had a large metal canister sitting on the shelf which was tipped towards the back of the cabinet. The same condition was observed during a previous inspection in July 2019.

ii. The surfaces of two blue tub lift seats, located in identified tub rooms were observed to be worn on an identified date in February 2020. The seats, where personal contact would be made by residents, were worn resulting in the surfaces being unhygienic as the surfaces were no longer sealed. [s. 15. (2) (c)]

Issued on this 27th day of May, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168)
Inspection No. / No de l'inspection :	2020_556168_0007
Log No. / No de registre :	017384-19, 020503-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 22, 2020
Licensee / Titulaire de permis :	Diversicare Canada Management Services Co., Inc. 5290 Yonge Street, Suite 200, NORTH YORK, ON, M2N-5P9
LTC Home / Foyer de SLD :	Hardy Terrace 612 Mount Pleasant Road, R.R. #2, BRANTFORD, ON, N3T-5L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deborah Langlois

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Diversicare Canada Management Services Co., Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_541169_0015, 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 must be compliant with s.15(1) of O. Reg. 79/10.

Specifically, the licensee shall complete the following:
1. Amend the home's Sleep Observation Record 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). This document is 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:
a) the alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the specified period of use or if no alternatives were trialled, document why they were not trialled; and
b) include the names of the interdisciplinary team members who participated in assessing the resident.

2. An interdisciplinary team shall assess all residents who use one or more bed

rails using the amended bed rail assessment form and document the assessed results and recommendations for each resident, including in the written plan of care.

3. Obtain or develop written material that can be made available for families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, how beds are determined to pass or fail entrapment zone testing, the role of the Substitute Decision Maker with respect to resident assessments.

4. Develop procedures that encompasses resident assessments and bed system evaluations. The procedures shall include but not be limited to the following guidance:
a) PSW role in monitoring residents while in bed with bed rails applied and the safety risks that need to be monitored for;
b) Substitute Decision Maker's role in making decisions about the application of bed rails;
c) The process for recognizing and reporting bed system deficiencies;
d) The process for reporting bed system changes to management staff (i.e. mattress exchanges); and
e) The name of the documents and references used to develop the policy.

5. Registered staff who complete the bed rail risk assessments shall have knowledge of the contents of the prevailing practices identified as 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) and the "Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, (U.S. F.D.A, 2006)".

6. All registered and non-registered staff shall be informed about the bed safety procedures and be provided with face to face education about bed system hazards (zones of entrapment and other injuries), regulatory requirements in Ontario regarding adult hospital beds, the risks and benefits of bed rail use, resident risk factors associated with increased risk of injury related to bed rail use, how to identify and report bed system deficiencies and any other relevant information identified in the prevailing practices.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee failed to comply with Compliance Order (CO) #001 from inspection report number 2019-541169-0015 (A1), dated November 4, 2019, with a compliance date of December 31, 2019.

The licensee was ordered to be compliant with s.15(1)(a) and (c) of O. Reg. 79/10.
Specifically, the licensee shall complete the following
1. Amend the home's existing "Bed Rail Assessment" 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). This document is 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:
a) questions that can be answered by the assessors related to the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to and after the application of any bed rails; and
b) the alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the specified period of use or if no alternatives were trialled, document why they were not trialled; and
c) include the names of the interdisciplinary team members who participated in assessing the resident.
2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed rail 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 assessing each resident using the amended bed rail assessment form.
Include in the written plan of care what position the bed rails are to be applied in, how many bed rails are to be applied and on what side. If any accessories or interventions (i.e. rail pads, bolsters) are required to mitigate any safety risks, the specific accessory and use instructions are to be included.
4. Obtain or develop written material that can be made available for families and

residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds are determined to pass or fail entrapment zone testing, the role of the Substitute Decision Maker and the licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.
5. Develop procedures that encompasses resident assessments and bed system evaluations. The procedures shall include but not be limited to the following guidance:
a) PSW role in monitoring residents while in bed with bed rails applied and the safety risks that need to be monitored for; and
b) Registered staff role in assessing residents where bed rails have been requested or indicated for use; and
c) Substitute Decision Maker's role in making decisions about the application of bed rails; and
d) Maintenance staff role in ensuring that the bed systems are evaluated as per Health Canada guidelines; and
e) The role of any other selected interdisciplinary members involved in the resident assessments; and
f) The available alternatives to bed rails and the accessories that are available to mitigate any identified risks or hazards; and
g) The process for recognizing and reporting bed system deficiencies; and
h) The process for reporting bed system changes to management staff (i.e. mattress exchanges); and
i) Guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
j) The name of the documents and references used to develop the policy.
6. Registered staff who complete the bed rail risk assessments shall have knowledge of the contents of the prevailing practices identified as 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) and the "Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, (U.S. F.D.A, 2006)".
7. All registered and non-registered staff shall be informed about the bed safety procedures and be provided with face to face education about bed system hazards (zones of entrapment and other injuries), regulatory requirements in

Ontario regarding adult hospital beds, the risks and benefits of bed rail use, resident risk factors associated with increased risk of injury related to bed rail use, how to identify and report bed system deficiencies and any other relevant information identified in the prevailing practices.
8. All bed systems shall be re-evaluated using the methods and processes described in the Health Canada guidelines and each bed frame and mattress is to be labelled with the same identifier. The results of the evaluation shall be documented.
9. Each bed system where bed rails are in use, whether in the guard or assist position, shall be modified so that the mattress does not slide side to side or move about on the deck of the bed.
10. All bed systems that are equipped with rotating assist rails that are loose and unstable and cannot be tightened or adjusted, shall be removed from the bed frame.

The licensee completed steps 1(a), 3, 5(b),(d),(e),(f),(i), 8, 9 and 10 for CO #001 from inspection report number 2019-541169-0015 (A1).

The licensee failed to complete steps 1(b)(c), 2, 4, 5(a),(c),(g),(h),(j), 6 and 7 for CO #001 from inspection report number 2019-541169-0015 (A1).

The licensee failed to ensure that where bed rails were used, five identified residents were assessed in accordance with prevailing practices, to minimize risk to the residents.

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.
The guide is cited in a document developed by Health Canada titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards”, March 2008.
The Health Canada guide was identified by the Director of the Ministry of Long Term Care in 2012 and 2019, as the prevailing practice with respect to bed safety.
According to the Clinical Guidance document, “in creating a safe bed

environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape". Once an interdisciplinary team has initially assessed a resident for their ability to use bed rails, and deemed them to be beneficial to the resident in their bed mobility activities, residents need to undergo additional monitoring for safety hazards. Residents need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk-related hazards associated with the application of one or more bed rails.
The Clinical Guidance document emphasizes the importance of establishing procedures and processes for bed safety monitoring. Monitoring includes but is not limited to who would monitor the residents, for how long and at what frequency, the specific hazards that would need to be monitored for while the resident is in bed with one or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails are available and trialled before the application of bed rails.

For this Follow-Up inspection, a Compliance Order (CO) that was previously issued on November 4, 2019, report number 2019-541169-0015 (A1), was reviewed to determine compliance. The CO directed the licensee to complete specific requirements to achieve compliance, those that were not complied with are listed below.

1. The Administrator reported that they had reviewed the clinical guidance documents and developed a program for bed safety. This program included a policy and procedure titled "Safe Use of Bed Rails", effective December 2, 2019, a Sleep Observation Record, a Bed Rail Utilization Quarterly Assessment, information for residents and family members related to bed rails, education for registered nursing staff and an auditing component.

A review of the policy and procedure "Safe Use of Bed Rails", effective December 2, 2019, with the Administrator, confirmed that the document, did not include, as previously required:
i. An assessment that required clear documentation of the alternatives that were trialled prior to the application of one of more bed rails and whether or not the alternatives were effective during the specified period of use or if no alternatives were trailed why they were not trailed, nor the names of the team members who participated in the assessment;

ii. The role of the PSW in monitoring residents while in bed, with bed rails applied, and the safety risks that they were to monitor for;
iii. The Substitute Decision Maker's role in making decisions about the application of bed rails;
iv. The process for recognizing and reporting bed system deficiencies and the process for reporting bed system changes to management staff; nor
v. The names of the documents and references used to develop the policy.

The Administrator identified that direction was provided to nursing staff to complete a Sleep Observation Record on all new residents and that other residents in the home, who already utilized bed rails would be assessed into the first quarter of 2020. Additionally direction was provided that if it was suspected that a resident no longer required the use of bed rail(s), staff were to complete a Sleep Observation Record, to assist in decision making regarding the safety and use of bed rails.
Interview with RN #105 and RPN #106 both indicated that to their knowledge currently only new admissions were assessed, using the Sleep Observation Record, not residents, previously residing in the home who utilized bed rails.

Information was provided to residents and families which included: a presentation at a Town Hall Meeting by the Administrator to discuss bed rails; the posting of a Bed Rail Fact Sheet in accessible locations in the home and a mail out pamphlet titled "A Guide to Bed Safety" created by the home.
On review of the information provided, it did not include the previously required information regarding: identification of the regulations and prevailing practices governing adult hospital beds in Ontario; how beds were assessed to determine if they passed or failed entrapment zone testing; nor the role of the Substitute Decision Maker in relation to bed rail use, as confirmed by the Administrator following a review of the documents.

RN #105 and RPNs #106 and #104 identified that they were responsible to complete bed rail risk assessments on residents but were not familiar with the prevailing practice documents "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" or "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards". The registered staff confirmed that they had recently received training regarding the new policy and procedure and

assessments to be completed; however, the training did not clearly include zones of entrapment, assessment of gaps, regulatory requirements in Ontario regarding adult hospital beds etc. as previously required.

RN #101 confirmed that they provided training to all registered staff regarding of the policy and procedure "Safe Use of Bed Rails" starting in December 2019; however, confirmed that they only provided training to registered nursing staff. Interview with the Administrator confirmed that information was not provided to all non-registered staff regarding the bed safety procedure nor face to face education about bed system hazards (zones of entrapment and other injuries), regulatory requirements in Ontario regarding adult hospital beds, the risk and benefits of bed rail use, resident risk factors associated with increased risk of injury related to bed rail use, how to identify and report bed system deficiencies and any other relevant information identified in the prevailing practices, as previously required.

2. Residents who utilized bed rails were observed and their clinical records were reviewed:
i. Resident #011 was observed in bed, on an identified date in February 2020, with one or more bed rails applied, which was consistent with the directions in their plan of care. Interview with the resident confirmed the use of the bed rails as per the plan. A review of the clinical record did not include a completed Sleep Observation Record nor a Bed Rail Utilization Quarterly Assessment, as confirmed by RPN #106.
ii. Resident #020 was observed in bed, on an identified date in February 2020, with one or more bed rails applied, which was consistent with the directions in their plan of care. A review of the clinical record did not include a completed Sleep Observation Record as confirmed by RN #105, following a review of the clinical record.
iii. Resident #017 confirmed the use of one or more bed rails when in bed, which was consistent with the directions in their plan of care. A review of the clinical record did not include a completed Sleep Observation Record nor a Bed Rail Utilization Quarterly Assessment, as confirmed by RPN #106.
iv. Resident #015 confirmed the use of one or more bed rails when in bed, which was consistent with the directions in their plan of care. A review of the clinical record did not include a completed Sleep Observation Record nor a Bed Rail Utilization Quarterly Assessment, as confirmed by RPN #106.

v. Resident #019 was observed in bed, on an identified date in February 2020, with one or more bed rails applied, which was consistent with the directions in their plan of care. A review of the clinical record did not include a completed Sleep Observation Record nor a Bed Rail Utilization Quarterly Assessment, as confirmed by RPN #106.
The five residents were not reassessed, since the previous inspection, as to whether alternatives to bed rails were trialled, the records did not include any current information about the residents' sleep behaviours and whether any risks were observed while sleeping in bed with bed rails applied. The risk over benefit of applying bed rails for resident use was not documented.

The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

1. The licensee failed to ensure that where bed rails were used, by four residents, that other safety issues related to the use of bed rails were addressed.

i. The bed system of resident #019 was observed on an identified date in February 2020. It was noted that the bed frame was equipped with bed rails. The bed rails were noted to be loose and moved back and forth with little effort. The resident was observed in bed on an identified date in February 2020, with one or more bed rails in the raised position. When tested the bed rails remained loose.
ii. The bed system of resident #016 was observed on an identified date in February 2020. It was noted that the bed frame was equipped with bed rails. When assessed one bed rail was noted to be loose and moved back and forth with little effort when positioned in raised positions. Interview with the resident confirmed that they used the bed rail when in bed.
On an identified date in February 2020, PSW #103 confirmed that the resident used the bed rail when in bed and in their opinion the bed rail was not loose.
iii. The bed system of resident #017 was observed on an identified date in February 2020. It was noted that the bed frame was equipped with bed rails. The bed rails were noted to be loose and moved back and forth with little effort. Interview with the resident confirmed that they used the bed rails when in bed.
iv. The bed system of resident #020 was observed on an identified date in

February 2020. It was noted that the bed frame was equipped with bed rails. A bed rail was noted to be loose and moved back and forth with little effort. The resident was observed in bed on an identified date in February 2020, with one or more bed rails in a raised position. When tested the rail remained loose.

On an identified date in February 2020, PSW #107 observed the bed rails utilized by resident #017 and PSW #108 observed the bed rails utilized by resident's #016, #019 and #020. Both PSWs confirmed, on movement of the bed rails and demonstration of the inspector, that one or more bed rails on each bed was loose.
A discussion was held with the Maintenance Supervisor on an identified date in February 2020, regarding bed rails. They identified awareness of the potential for the bed rails to become loosened over time with use. The condition of the identified bed rails were discussed and all but one of the bed rails were tightened the same day, with the last bed rail tightened at a later date.

Discussion with the Administrator identified a plan to provide additional training to staff regarding bed rails and the safe use of, as well as to include bed rails and a schedule for preventative maintenance of bed rails into their Maintenance Care software program.

The severity of this issue was determined to be a level 2 or minimal risk to the residents.
The scope of the issue was determined to be widespread in a number of rooms in the home.
The home had a compliance history of a level 5, with this re-issued CO to the same subsection initially identified in Inspection Report 2019-541169-0015 (A1), dated November 4, 2019, with a compliance due date of December 31, 2019, and the home had a history of four or more COs (complied or outstanding) in the past 36 months. Additionally, the home had a history of 6 other COs in the last 36 months.

(168)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 01, 2020

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 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 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 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 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 22nd day of May, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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