Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2019	2018_539120_0046 (A2)	026152-17	Follow up

Licensee/Titulaire de permis

Heritage Green Nursing Home
353 Isaac Brock Drive STONEY CREEK ON L8J 2J3

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

Heritage Green Nursing Home
353 Isaac Brock Drive STONEY CREEK ON L8J 2J3

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

Amended by BERNADETTE SUSNIK (120) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

The public report was amended to remove personal health information.

Issued on this 26th day of February, 2019 (A2)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by BERNADETTE SUSNIK (120) - (A2)

Amended 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): October 29, 30, 2018

A Resident Quality Inspection (2017-574586-0009) was conducted between April and May 2017, at which time non-compliance was identified related to the

home's bed safety program. A Compliance Order (CO #002) was issued in May 2017, with a compliance due date of June 2017.

A follow up inspection (2018-539120-0056) was conducted in October 2017, which revealed that not all of the conditions laid out in CO #002 were complied with and a second CO was issued in November 2017, with a compliance due date of June 2018.

For this follow up inspection, the conditions laid out in the CO have not all been complied with and the CO is being re-issued for the third time. Due to repeated issuance of the same CO, a Director Referral is also being issued. See below for details.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Staff Development Co-ordinator, Registered Nurse (RN) and Personal Support Workers (PSWs).

During the course of the inspection, the inspector toured several home areas and observed resident bed systems, reviewed written bed safety procedures, bed system audits for entrapment zones, resident bed safety assessments and resident clinical records.

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

During the course of the original 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	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 :

(A2)
1. The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices, to minimize risk to the resident.

Two previous inspections were made, one in April 2017, and a follow up inspection in October 2017, related to resident assessments where bed rails were used or applied. Both inspections resulted in the issuance of a compliance order (CO). The CO's included multiple requirements related to the licensee's bed safety related policies and procedures, clinical assessment forms, assessment process, and staff education in being able to assess the resident in accordance with bed safety related prevailing practices. The prevailing practice used to determine compliance related to this section included the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", (U.S. F.D.A, April 2003)".

In accordance with s.15(1) of O. Reg. 79/10, the licensee was required to ensure that requirements previously laid out in CO #001 from inspection report #2017-539120-0056 was complied with by June 2018. Specifically, the licensee was to comply with the following;

1. Amend the home's existing "Bed Risk Assessment" form and process related to resident clinical assessments and the use of bed rails to include additional 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) which is recommended as the prevailing practice for individualized resident assessment of bed rails. The amended form and or process shall, at a minimum, include questions related to the following;
a. the observation of the resident while sleeping for a specified period of time, to establish their bed mobility status, medical condition, medication use, behaviours and other relevant risk factors prior to the application of any bed rail or bed system accessory (bed remote control) or alternative to bed rails (bolster, positioning rolls, roll guards); and
b. the observation of the resident while sleeping for a specific period of time, to establish any safety risks to the resident after a bed rail, accessory or alternative has been applied and deemed necessary; and
c. the alternative or alternatives that were trialled prior to applying one or more bed rails and document whether the alternative was effective or not during a specified observation period.

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

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. The written plan of care shall include at a minimum information about the resident's ability to independently use the bed rail(s) or whether staff supervision is required, why bed rails are being used or applied, how many, on what side of the bed, bed rail type or size and when they are to be applied (when in bed, at all times, when care provided etc).

4. Develop or acquire information fact sheets or pamphlets identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks/hazards of bed rail use, available alternatives to bed rails, how residents are assessed upon admission, how bed systems are evaluated for entrapment zones, the role of both the substitute decision maker (SDM) and licensee with respect to resident assessments and any other relevant information regarding bed safety. The information shall be disseminated to relevant staff, families and residents

and/or SDM.

5. Amend the policy titled "Bed Rails" to include additional and relevant information noted in 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 "A Guide for Modifying Bed Systems and Using Accessories to Reduce Entrapment, (U.S. F.D.A, June 2006). At a minimum the policy shall include links to the above noted guidelines and;
a) additional details of the process of assessing residents upon admission, after admission and when a change in the resident's condition has been identified and when a change to the bed system has been made to monitor residents for risks associated with bed rail use and the use of any bed related attachments/accessories on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the interdisciplinary team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
c) what specific options are available to mitigate any identified bed safety related hazards such as entrapment, suspension or injury risks; and
d) the role of the SDM and/or resident in selecting the appropriate device for the resident's unique identified care needs; and
e) who the interdisciplinary team members are in assessing each resident and their specific roles and responsibilities 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;
f) what alternatives are available for trial before deciding that bed rails are the ideal option, how they will be tested to determine safety, effectiveness and comfort in addition to; how long they would be trialled for, who would monitor the resident, when and how often and what specific safety hazards associated with the alternative would be monitored for; and
g) links to references used to develop the policy

6. Provide face to face training to all relevant staff [personal support workers (PSWs), registered staff, OT/PT] who are affiliated with residents and/or their bed systems with respect to the home's amended bed safety assessment policies and procedures and associated forms.

The licensee failed to complete 1 b,c, 2, 3, 4, 5 b, c, d, f.

A review of the licensee's current bed rail related risk assessment form was conducted with the Staff Development Co-ordinator (SDC), who was the lead in amending the forms and processes related to bed safety. In addition, the licensee hired an external consultant to assist with the redevelopment of the program. The clinical assessment form was renamed "Bedrails Assessment", and included additional questions related to resident risk factors for bed related injury as per requirement 1a.

With respect to 1b, only one question was included related to observations of the resident while in bed with bed rails applied, to establish safety risks. The question was whether the resident attempted to climb over or around the bed rails. There was no link to or reference to any other processes or data collected by other interdisciplinary team members related to observing the resident in bed with one or more bed rails applied. According to the SDC, PSWs were tasked at observing residents in bed at all times for any number of safety issues, including bed system related hazards. PSWs were to complete on each shift, forms entitled "sleep mobility" and "quality of sleep". Neither of these forms included any questions related to bed safety [i.e sleeping with limbs in various zones in and around the bed rail, sleeping up against the bed rail, torso partially off the bed] but focused on how much assistance the resident required to reposition in bed and whether they slept soundly, were restless or wandering. Other concerns were to be brought to the attention of the registered staff who were required to document the concern in the resident's electronic chart. The SDC stated that the registered staff were to review the PSW task forms and incorporate the results as part of their decision making to determine the extent of risk associated with bed rail use. The process was not clarified in the licensee's policies.

With respect to 1c, interventions were listed such as bed in lowest position while in bed, but no alternatives to replace bed rail use were available for the assessor to chose from a selection of options. Alternatives are options that replace bed rail use and interventions include options that are implemented with or without bed rails. This distinction was not clear.

Requirement #2 is linked to requirement #5b below.

Requirement #3 included updating the plan of care for each resident who used one or more bed rails to identify whether the resident could use the bed rails independently or required staff assistance. The plan of care for residents #101,

#103 and #104 reviewed below did not include the size or type of bed rail or whether the resident could use them independently or not.

According to the SDC, no fact sheets or pamphlets were developed in accordance with requirement #4 of the CO because they considered their facility to be "bed rail free". Approximately 54 bed systems in the home were confirmed during the inspection to be equipped with one or more bed rails. The bed rails were either quarter length rotating assist rails or quarter length bed rails that slid up and down. The bed rails when checked, were noted to be fixed in place with plastic ties or a bolt to prevent them from moving up and down or rotating. The SDC identified the fixed rails as "positioning rails" and therefore considered their facility free of "bed rails". The SDC was advised that any bed rail, despite size or function was considered a bed rail and that s. 15(1) would apply.

The licensee's most recent policy provided by the DOC entitled "Bedrail Device Assessment" NUR-05-03-40 dated 2012, was developed by an external consultant that the licensee hired to assist them in amending their bed safety program. Requirement #5 was reviewed with the SDC, point by point, and verification was made that the policy did not include any information related to what specific options were available to mitigate any identified bed safety related hazards such as entrapment, suspension or injury risks, the role of the SDM and/or resident in selecting the appropriate device for the resident's unique identified care needs, the role of the PSW related to observing residents while in bed for safety hazards and what alternatives were available for trial before deciding that bed rails were the ideal option for the resident [including how long the trial period should be, who would monitor the alternative, when and how often and what, if any hazards were associated with the alternative]. The reason provided as to why the specific points were not included were based on the belief that the bed rails in the home were not considered bed rails, but "positioning rails" and therefore did not require their staff to use alternatives or to consider options to mitigate risk.

Requirement #5b, with respect to what guidance was available to the assessors completing the bed rail assessments, a decision tree was provided for review. The decision tree guided the assessor in establishing whether the resident was at risk of falling from bed and the extent of the resident's bed mobility. Depending on the answers, the assessor was therefore guided to either use "assist rails or half rails" or to implement strategies for those at risk of falling. The decision tree nor the policy included any guidance related to basing a decision to use or not use

bed rails based on the data acquired by the interdisciplinary team members and to conclude and document the risk versus the benefits of the application of one or more bed rails.

During this inspection, residents #101, #103 and #104, who were previously identified during the inspection conducted in October 2017, were selected to determine if they were adequately assessed for risk if bed rails were in use. All three were re-assessed in 2018, however, their was no conclusion as to whether the risks outweighed the benefits for bed rail use.

Resident #101 was admitted to the home in 2016, and their bed was observed to be equipped with bed rails. One side was in a particular position. The resident's bed system had been replaced since the previous inspection in October 2017.

The resident's written plan of care, revised in October 2018, identified that the resident had several health conditions increasing their risk of bed system related injury and required staff assistance for certain activities. Bed rails were to be applied when in bed for repositioning. Although the plan included that staff were required to move and reposition the resident in bed and to encourage the resident to use the bed rails, it was unclear whether the resident actually used the bed rails. The type of bed rail to be used was not specified.

The Bedrails Assessment (BRA) form completed in June 2018, included that the resident had numerous risk factors associated with a higher prevalence for bed system injury. RPN #001, who completed the form, selected that the bed rails were both a personal preference of the resident and that the bed rails were recommended for the resident for bed mobility. No alternatives to the bed rails were documented as trialled. The size of the bed rail was not selected. No risk over benefit conclusion was included on the form and no link to any sleep observations was made. Progress notes did not include any conclusions about the resident's overall safety risks associated with the bed system provided. Based on the discussion with the RN, the resident needed the bed rails for bed mobility. The RPN was not certain as to their entrapment or suspension risk and did not consider any alternatives as the resident had bed rails for several years without any incidences.

Resident #103 was admitted to the home in 2016, and was observed in bed during the inspection with bed rails in a particular position. The resident's written plan of care identified that the resident had several health conditions that

increased their risk of bed system injury and needed assistance with certain activities. Bed rails were to be used when in bed to assist with positioning. Although the plan included that staff were required to move and reposition the resident in bed and to encourage the resident to use the bed rails, it was unclear whether the resident actually used the bed rails. The type of bed rail being used was not specified.

The BRA form completed by RPN #001 in June 2018, included that the resident had several risk factors associated with a higher prevalence for bed system injury. Several of the risk factors identified in the plan of care were not included in the BRA. The RN documented that a bed rail was trialled for up to 30 days, but did not include when and what the outcome was. The RN selected that bed rails were to be used for security, as a transfer aid and for bed mobility. The size of the rail was not selected. Under the section of the form dedicated to the summary of actions, the RN identified that the resident was recommended to have bed rails for positioning and bed mobility. No risk over benefit conclusion was included on the form and no link to any sleep observations was made. Progress notes did not include any conclusions about the resident's overall safety risks associated with the bed system provided.

The resident's PSW #009 identified how the resident slept and their positioning capabilities. Documentation that was reviewed included the resident's bed mobility tasks, completed by PSWs on various shifts. The PSW's identified that the resident required one to two staff to provide extensive assistance with bed mobility such as turning side to side or to and from a lying position throughout the month of October 2018. The bed mobility and sleep quality information gathered by the PSWs was not included on the assessment form.

Resident #104 was admitted to the home in 2014, and their bed system was observed with bed rails at the time of inspection. The resident received a different bed system since the last inspection conducted in October 2017. The resident's current written plan of care identified that the resident had several health conditions that would increase their risk of bed system related injury. The resident required two staff to transfer them, required repositioning every two hours and bed rails up at all times when in bed to assist with positioning. Although the plan included that staff were required to move and reposition the resident in bed and to encourage the resident to use the bed rails, it was unclear whether the resident actually used the bed rails. The type of bed rail to be used was not specified. RPN #001, when asked about the resident's ability to use the bed rails,

stated that the resident used the bed rail to hold onto the bed rail for bed mobility.

The BRA form completed in June 2018, by RPN #001, included that the resident had several risk factors associated with a higher prevalence for bed system injury. Several of the risk factors identified in the plan of care were not included in the BRA. The RPN documented that two bed rails were trialled as an alternative for up to 30 days. However, it was unclear why bed rails were considered as alternatives. The RPN selected that bed rails were to be used as per the resident's personal preference for security, as a transfer aid and for bed mobility. The size of the rail was not selected. Under the section of the form dedicated to the summary of actions, the RPN identified that the resident was recommended to have bed rails for positioning and bed mobility. No risk over benefit conclusion was included on the form and no link to any sleep observations was made. Progress notes did not include any conclusions about the resident's overall safety risks associated with the bed system provided.

The conclusions related to these residents and the use of their bed rails lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

The licensee therefore failed to assess the residents that used one or more bed rails in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 26th day of February, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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) :	Amended by BERNADETTE SUSNIK (120) - (A2)
Inspection No. / No de l'inspection :	2018_539120_0046 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	026152-17 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 26, 2019(A2)
Licensee / Titulaire de permis :	Heritage Green Nursing Home 353 Isaac Brock Drive, STONEY CREEK, ON, L8J-2J3
LTC Home / Foyer de SLD :	Heritage Green Nursing Home 353 Isaac Brock Drive, STONEY CREEK, ON, L8J-2J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	J. Scott Kozachenko

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Heritage Green Nursing Home, 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_0056, 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 be compliant with s.15(1)(a) of O. Reg 79/10.

Specifically, the licensee shall complete the following:

1. Amend the home's existing "Bedrails Assessment" form and process related to resident clinical assessments and the use of bed rails to include additional 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) which is recommended as the prevailing practice for individualized resident assessment of bed rails. The amended form and or process shall, at a minimum, include questions related to the following;

a. potential safety risks associated with the resident while they were observed sleeping for a specific period of time, after a bed rail, accessory or alternative has been applied and deemed necessary; and
b. possible alternative(s) that were trialled prior to applying one or more bed

rails and document why the alternative was appropriate or effective or not during a specified observation period. If no alternative was appropriate for trial, document why.

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

3. Update the written plan of care for those residents who have been provided with one or more bed rails to include information about the bed rail type or size, resident's ability to independently use the bed rail(s) or whether staff supervision is required.

4. Develop or acquire information fact sheets or pamphlets identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks/hazards of bed rail use, available alternatives to bed rails, how residents are assessed upon admission, how bed systems are evaluated for entrapment zones, the role of both the substitute decision maker (SDM) and licensee with respect to resident assessments and any other relevant information regarding bed safety. The information shall be provided to newly admitted residents and/or their SDM.

5. Amend the policy entitled ""Bedrail Device Assessment" NUR-05-03-40 dated 2012 to include additional and relevant information noted in 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 "A Guide for Modifying Bed Systems and Using Accessories to Reduce Entrapment, (U.S. F.D.A, June 2006). At a minimum the policy shall include links to the above noted guidelines and;
a) guidance for the assessors in being able to make clear decisions based on the data acquired by the interdisciplinary team members and to conclude

and document the risk versus the benefits of the application of one or more bed rails for residents; and
b) what specific options are available to mitigate any identified bed safety related hazards such as entrapment, suspension or injury risks; and
c) the role of the SDM and/or resident in selecting the appropriate device for the resident's unique identified care needs; and
d) what alternatives are available for trial before deciding that bed rails are the ideal option, how they will be tested to determine safety, effectiveness and comfort in addition to; how long they would be trialled for, who would monitor the resident, when and how often and what specific safety hazards associated with the alternative would be monitored for.

Grounds / Motifs :

(A2)
1. The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices, to minimize risk to the resident.

Two previous inspections were made, one in April 2017, and a follow up inspection in October 2017, related to resident assessments where bed rails were used or applied. Both inspections resulted in the issuance of a compliance order (CO). The CO's included multiple requirements related to the licensee's bed safety related policies and procedures, clinical assessment forms, assessment process, and staff education in being able to assess the resident in accordance with bed safety related prevailing practices. The prevailing practice used to determine compliance related to this section included the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", (U.S. F.D.A, April 2003)".

In accordance with s.15(1) of O. Reg. 79/10, the licensee was required to ensure that requirements previously laid out in CO #001 from inspection report #2017-539120-0056 was complied with by June 29, 2018. Specifically, the licensee was to comply with the following;

1. Amend the home's existing "Bed Risk Assessment" form and process related to resident clinical assessments and the use of bed rails to include additional 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) which is recommended as the prevailing practice for individualized resident assessment of bed rails. The amended form and or process shall, at a minimum, include questions related to the following;
a. the observation of the resident while sleeping for a specified period of time, to establish their bed mobility status, medical condition, medication use, behaviours and other relevant risk factors prior to the application of any bed rail or bed system accessory (bed remote control) or alternative to bed rails (bolster, positioning rolls, roll guards); and
b. the observation of the resident while sleeping for a specific period of time, to establish any safety risks to the resident after a bed rail, accessory or alternative has been applied and deemed necessary; and
c. the alternative or alternatives that were trialled prior to applying one or more bed rails and document whether the alternative was effective or not during a specified observation period.

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

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. The written plan of care shall include at a minimum information about the resident's ability to independently use the bed rail(s) or whether staff supervision is required, why bed rails are being used or applied, how many, on what side of the bed, bed rail type or size and when they are to be applied (when in bed, at all times, when care provided, etc).

4. Develop or acquire information fact sheets or pamphlets identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks/hazards of bed rail use, available alternatives to bed rails, how residents are assessed upon admission, how bed systems are evaluated for entrapment zones, the role of both the substitute decision maker (SDM) and licensee with respect to resident

assessments and any other relevant information regarding bed safety. The information shall be disseminated to relevant staff, families and residents and/or SDM.

5. Amend the policy titled "Bed Rails" to include additional and relevant information noted in 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 "A Guide for Modifying Bed Systems and Using Accessories to Reduce Entrapment, (U.S. F.D.A, June 2006). At a minimum the policy shall include links to the above noted guidelines and;
a) additional details of the process of assessing residents upon admission, after admission and when a change in the resident's condition has been identified and when a change to the bed system has been made to monitor residents for risks associated with bed rail use and the use of any bed related attachments/accessories on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the interdisciplinary team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
c) what specific options are available to mitigate any identified bed safety related hazards such as entrapment, suspension or injury risks; and
d) the role of the SDM and/or resident in selecting the appropriate device for the resident's unique identified care needs; and
e) who the interdisciplinary team members are in assessing each resident and their specific roles and responsibilities 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;
f) what alternatives are available for trial before deciding that bed rails are the ideal option, how they will be tested to determine safety, effectiveness and comfort in addition to; how long they would be trialled for, who would monitor the resident, when and how often and what specific safety hazards associated with the alternative would be monitored for; and
g) links to references used to develop the policy

6. Provide face to face training to all relevant staff [personal support workers (PSWs), registered staff, OT/PT] who are affiliated with residents and/or their bed systems with respect to the home's amended bed safety assessment policies and procedures

and associated forms.

The licensee failed to complete 1 b,c, 2, 3, 4, 5 b, c, d, f.

A review of the licensee's current bed rail related risk assessment form was conducted with the Staff Development Co-ordinator (SDC), who was the lead in amending the forms and processes related to bed safety. In addition, the licensee hired an external consultant to assist with the redevelopment of the program. The clinical assessment form was renamed "Bedrails Assessment", and included additional questions related to resident risk factors for bed related injury as per requirement 1a.

With respect to 1b, only one question was included related to observations of the resident while in bed with bed rails applied, to establish safety risks. The question was whether the resident attempted to climb over or around the bed rails. There was no link to or reference to any other processes or data collected by other interdisciplinary team members related to observing the resident in bed with one or more bed rails applied. According to the SDC, PSWs were tasked at observing residents in bed at all times for any number of safety issues, including bed system related hazards. PSWs were to complete on each shift, forms entitled "sleep mobility" and "quality of sleep". Neither of these forms included any questions related to bed safety [i.e sleeping with limbs in various zones in and around the bed rail, sleeping up against the bed rail, torso partially off the bed] but focused on how much assistance the resident required to reposition in bed and whether they slept soundly, were restless or wandering. Other concerns were to be brought to the attention of the registered staff who were required to document the concern in the resident's electronic chart. The SDC stated that the registered staff were to review the PSW task forms and incorporate the results as part of their decision making to determine the extent of risk associated with bed rail use. The process was not clarified in the licensee's policies.

With respect to 1c, interventions were listed such as bed in lowest position while in bed, but no alternatives to replace bed rail use were available for the assessor to chose from a selection of options. Alternatives are options that replace bed rail use and interventions include options that are implemented with or without bed rails. This distinction was not clear.

Requirement #2 is linked to requirement #5b below.

Requirement #3 included updating the plan of care for each resident who used one or more bed rails to identify whether the resident could use the bed rails independently or required staff assistance. The plan of care for residents #101, #103 and #104 reviewed below did not include the size or type of bed rail or whether the resident could use them independently or not.

According to the SDC, no fact sheets or pamphlets were developed in accordance with requirement #4 of the CO because they considered their facility to be "bed rail free". Approximately 54 bed systems in the home were confirmed during the inspection to be equipped with one or more bed rails. The bed rails were either quarter length rotating assist rails or quarter length bed rails that slid up and down. The bed rails when checked, were noted to be fixed in place with plastic ties or a bolt to prevent them from moving up and down or rotating. The SDC identified the fixed rails as "positioning rails" and therefore considered their facility free of "bed rails". The SDC was advised that any bed rail, despite size or function was considered a bed rail and that s. 15(1) would apply.

The licensee's most recent policy provided by the DOC entitled "Bedrail Device Assessment" NUR-05-03-40 dated 2012, was developed by an external consultant that the licensee hired to assist them in amending their bed safety program. Requirement #5 was reviewed with the SDC, point by point, and verification was made that the policy did not include any information related to what specific options were available to mitigate any identified bed safety related hazards such as entrapment, suspension or injury risks, the role of the SDM and/or resident in selecting the appropriate device for the resident's unique identified care needs, the role of the PSW related to observing residents while in bed for safety hazards and what alternatives were available for trial before deciding that bed rails were the ideal option for the resident [including how long the trial period should be, who would monitor the alternative, when and how often and what, if any hazards were associated with the alternative]. The reason provided as to why the specific points were not included were based on the belief that the bed rails in the home were not considered bed rails, but "positioning rails" and therefore did not require their staff to use alternatives or to consider options to mitigate risk.

Requirement #5b, with respect to what guidance was available to the assessors

completing the bed rail assessments, a decision tree was provided for review. The decision tree guided the assessor in establishing whether the resident was at risk of falling from bed and the extent of the resident's bed mobility. Depending on the answers, the assessor was therefore guided to either use "assist rails or half rails" or to implement strategies for those at risk of falling. The decision tree nor the policy included any guidance related to basing a decision to use or not use bed rails based on the data acquired by the interdisciplinary team members and to conclude and document the risk versus the benefits of the application of one or more bed rails.

During this inspection, residents #101, #103 and #104, who were previously identified during the inspection conducted on October 19, 2017, were selected to determine if they were adequately assessed for risk if bed rails were in use. All three were re-assessed in 2018, however, their was no conclusion as to whether the risks outweighed the benefits for bed rail use.

Resident #101 was admitted to the home in 2016, and their bed was observed to be equipped with bed rails. One side was in a particular position. The resident's bed system had been replaced since the previous inspection in October 2017.

The resident's written plan of care, revised in October 2018, identified that the resident had several health conditions increasing their risk of bed system related injury and required staff assistance for certain activities. Bed rails were to be applied when in bed for repositioning. Although the plan included that staff were required to move and reposition the resident in bed and to encourage the resident to use the bed rails, it was unclear whether the resident actually used the bed rails. The type of bed rail to be used was not specified.

The Bedrails Assessment (BRA) form completed in June 2018, included that the resident had numerous risk factors associated with a higher prevalence for bed system injury. RPN #001, who completed the form, selected that the bed rails were both a personal preference of the resident and that the bed rails were recommended for the resident for bed mobility. No alternatives to the bed rails were documented as trialled. The size of the bed rail was not selected. No risk over benefit conclusion was included on the form and no link to any sleep observations was made. Progress notes did not include any conclusions about the resident's overall safety risks associated with the bed system provided. Based on the discussion with the RN, the resident needed the bed rails for bed mobility. The RPN was not certain as to their

entrapment or suspension risk and did not consider any alternatives as the resident had bed rails for several years without any incidences.

Resident #103 was admitted to the home in 2016, and was observed in bed during the inspection with bed rails in a particular position. The resident's written plan of care identified that the resident had several health conditions that increased their risk of bed system injury and needed assistance with certain activities. Bed rails were to be used when in bed to assist with positioning. Although the plan included that staff were required to move and reposition the resident in bed and to encourage the resident to use the bed rails, it was unclear whether the resident actually used the bed rails. The type of bed rail being used was not specified.

The BRA form completed by RPN #001 in June 2018, included that the resident had several risk factors associated with a higher prevalence for bed system injury. Several of the risk factors identified in the plan of care were not included in the BRA. The RN documented that a bed rail was trialled for up to 30 days, but did not include when and what the outcome was. The RN selected that bed rails were to be used for security, as a transfer aid and for bed mobility. The size of the rail was not selected. Under the section of the form dedicated to the summary of actions, the RN identified that the resident was recommended to have bed rails for positioning and bed mobility. No risk over benefit conclusion was included on the form and no link to any sleep observations was made. Progress notes did not include any conclusions about the resident's overall safety risks associated with the bed system provided.

The resident's PSW #009 identified how the resident slept and their positioning capabilities. Documentation that was reviewed included the resident's bed mobility tasks, completed by PSWs on various shifts. The PSW's identified that the resident required one to two staff to provide extensive assistance with bed mobility such as turning side to side or to and from a lying position throughout the month of October 2018. The bed mobility and sleep quality information gathered by the PSWs was not included on the assessment form.

Resident #104 was admitted to the home in 2014, and their bed system was observed with bed rails at the time of inspection. The resident received a different bed system since the last inspection conducted in October 2017. The resident's current written plan of care identified that the resident had several health conditions that would increase their risk of bed system related injury. The resident required two

staff to transfer them, required repositioning every two hours and bed rails up at all times when in bed to assist with positioning. Although the plan included that staff were required to move and reposition the resident in bed and to encourage the resident to use the bed rails, it was unclear whether the resident actually used the bed rails. The type of bed rail to be used was not specified. RPN #001, when asked about the resident's ability to use the bed rails, stated that the resident used the bed rail to hold onto the bed rail for bed mobility.

The BRA form completed in June 2018, by RPN #001, included that the resident had several risk factors associated with a higher prevalence for bed system injury. Several of the risk factors identified in the plan of care were not included in the BRA. The RPN documented that two bed rails were trialled as an alternative for up to 30 days. However, it was unclear why bed rails were considered as alternatives. The RPN selected that bed rails were to be used as per the resident's personal preference for security, as a transfer aid and for bed mobility. The size of the rail was not selected. Under the section of the form dedicated to the summary of actions, the RPN identified that the resident was recommended to have bed rails for positioning and bed mobility. No risk over benefit conclusion was included on the form and no link to any sleep observations was made. Progress notes did not include any conclusions about the resident's overall safety risks associated with the bed system provided.

The conclusions related to these residents and the use of their bed rails lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

The licensee therefore failed to assess the residents that used one or more bed rails in accordance with prevailing practices, to minimize risk to the resident.

This compliance order (CO) 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). The home had a level 4 history as they had on-going non-compliance with this section of O. Reg. 79/10 that included:
• compliance order (CO) #002 issued May 30, 2017 with a compliance due date of

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

June 30, 2017 (2017-574586-0009)
• compliance order (CO) #001 issued November 6, 2017 (CO) with a compliance due date of June 29, 2018 (2017-539120-0056)
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 31, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 26th day of February, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by BERNADETTE SUSNIK (120) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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