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 le Loi de 2007 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 24, 2018;	2018_593573_0001 (A1) (Appeal\Dir#: DR# 083)	015049-17	Follow up

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

The Salvation Army Ottawa Grace Manor
1156 Wellington Street OTTAWA ON K1Y 2Z3

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Amended by KAREN SIMPSON (Director) - (A1)(Appeal\Dir#: DR# 083)

Amended Inspection Summary/Résumé de l’inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector’s order(s): CO#002.
The Director’s review was completed on March 19, 2018.
Order(s) CO#002 was/were rescinded to reflect the Director’s review DR# 083.

Issued on this 24 day of April 2018 (A1)(Appeal\Dir#: DR# 083)

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

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

Amended by KAREN SIMPSON (Director) - (A1)(Appeal/Dir# DR# 083)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 12, 15, 16, 17, 18, 19, 22 and 23, 2018.

This follow up inspection was related to Compliance Order #001 from Resident Quality Inspection #2017_593573_0013 issued on August 30, 2017, regarding the use of bed rails

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Director of Employee Relations, Environmental Services Coordinator, the Scheduler, Maintenance Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector(s) observed residents' bed systems, reviewed resident health care records, reviewed the licensee's "Individual Assessment Form - Bed Rail Use", documentation related to bed system evaluations in the home, reviewed policies related to bed safety and prevention of entrapment.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Safe and Secure Home

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On August 30, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_593573_0013. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance.

The compliance order due date was November 22, 2017.

Parts 1, 4 and 5 of the compliance order were related to evaluation of resident's bed system with bed rails and parts 2 to 3 of the compliance order were related to the assessment of residents. The parts of the compliance order that have not been complied with will be referenced and addressed below.

Part 2 and part 3 of the compliance order required the licensee to take the following actions:

2. Ensure that an interdisciplinary team assess all residents in the home who use any type of bed rails, in accordance with the 2003 FDA prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings". The assessment shall include the assessment of the relative risk of using the bed rails

compared with not using them for an individual resident. The assessment is to occur before a decision to use or to discontinue the use of a bed rail is made.

3. Ensure that the above assessments are documented including the names of team members participating in the assessment, the results of the assessment including the risk benefit assessment, and the recommendations.

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008” (HC guidance document). In the memo, it is indicated that the Ministry expects homes to use the HC Guidance Document as a best practices document in their home.

The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States.

The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is specified that any decision to use or to discontinue use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. Numerous factors are to be considered and are specified.

The process is to result in a documented risk benefit assessment, prior to the team’s conclusion that bed rails may be indicated for use. Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:
a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.
b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the

resident.
c) Comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident.

The 2003 FDA Clinical Guidance document specifies that where clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On January 12, 2018, during an interview, the home's DOC indicated to the Inspector that the licensee uses an "Individual Assessment Form - Bed Rail Use" to evaluate all residents in the home who use any type of bed rails. Further, she indicated that the resident individual assessment form was to be completed with an interdisciplinary team.

On January 15, 2018, Inspector #573 observed resident #002 and #004's bed system, both bed systems were noted to have two bed rails in the up position. It was confirmed through observation and staff interviews that the bed rails were used for the above identified residents.

Inspector #573 reviewed resident #002 and #004's health care records and the Individual Assessment Form - Bed Rail Use.

Resident #002 was admitted to the home on an identified date, with multiple diagnosis. Resident's health care records indicated that resident #002 was at risk for falls. Further, the resident's written current plan of care identified the use of two ¼ bed rails to provide assistance with bed mobility.

Resident #004 was admitted to the home on an identified date, with multiple diagnosis. Resident's health care records related to resident's diagnosis, indicated that resident #004 was at risk of falling out of bed and at risk for injury. The resident's current written plan of care identified the use of two 1/2 padded bed rails as a restraint and further identified the bed rails were not used for bed mobility.

Upon review of resident #002 and #004's Individual Assessment Form Bed Rail Use, the Inspector noted that the form does not include the resident "diagnosis"

and there were no questions related to resident's ability to "toilet self safely" and "communication". The Inspector noted that the form did not appear to provide for the documentation of a risk benefit assessment as per the 2003 FDA Clinical Guidance document. Resident #002 and #004's Individual Assessment Form Bed Rail Use identified multiple risk factors. For resident #002, in the Individual Assessment Form Bed Rail Use under, recommendations, it was indicated that side rails were recommended due to resident's SDM being fearful of resident's falls. For resident #004, the individual assessment form bed rail use, indicated that the resident needed bed rails for mobility. Whereas resident #004's written plan of care in place indicated the bed rails were not used for bed mobility. Upon further review, Inspector noted that the assessment process failed to provide any information regarding how the benefits outweigh the risk of entrapment for the resident. The assessment process does not provide for the determination of relative risk of using bed rails compared with not using them for the resident. The assessment form does include the other interventions that were tried but does not identify why other care interventions were not appropriate or effective if attempted. The assessment process does not document a risk-benefit assessment that demonstrates that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or that a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them.

On January17, 2018, Inspector #573 met with the home's DOC and ADOC. Following discussion about the Individual Assessment Form Bed Rail Use, both the DOC and ADOC indicated that the assessment form does not include the resident diagnosis and there were no questions related to resident's ability to toilet self safely and communication. Regarding the notion of risk benefit assessment as per the 2003 FDA Clinical Guidance document, the DOC and ADOC indicated that the assessment form does not provide for a documented risk benefit assessment, and also indicated that documented risk benefit assessment was not being captured elsewhere within the resident's health care records.

In summary, the licensee has failed to comply with all aspects of Compliance Order #001, issued as a result of Resident Quality Inspection #2017_593573_0013. As a result of the continuing widespread non-compliance, which presents the potential for actual harm, a subsequent Compliance Order will be served to the licensee. [s. 15. (1) (a)]

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. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that the following prohibited devices that limit resident #004's movement (restraint) were not used in the home.

In accordance with LTCHA 2007, s.35, every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

In accordance with the O.Reg 79/10, s.112. 7, every licensee of a long-term care

home shall ensure that the following devices are not used in the home: Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Resident #004 was admitted to the home on an identified date, with multiple diagnosis. Related to the resident's diagnosis resident at risk of falling out of bed and at risk for injury.

On January 22, 2018, Inspector #573 observed resident #004 lying on a mattress with an specific device that limits resident #004's movements.

Resident #004 health care records were reviewed by Inspector #573. The plan of care for resident #004 indicated that the resident is at high risk for falls and injury to self. In the resident's current written plan of care, under restraints, the device was identified as a specified restraint device. Further, the written plan of care indicated the use of the specified restraint device for the resident as requested by the resident's substitute decision maker (SDM).

On January 22, 2018, during an interview, PSW #101 and PSW #102 indicated that the specified restraint device was used for resident #004's safety. PSW #101 indicated that the device helps to keep the resident in the bed, prevents from falls and injuries.

On January 22, 2018, during an interview, RPN #103 indicated the use of specified device as a restraint as per SDM request. Further, RPN #103 indicated that the resident is not able to cognitively or physically remove the restraint.

On January 23, 2018, Inspector spoke with the home's DOC who indicated that resident #004 was admitted in the home with high risk for falls and injury to self related to resident's diagnosis. The DOC stated to inspector that considering resident's specific diagnosis, various strategies and restraint alternatives were considered to prevent resident #004's fall and injuries. The DOC indicated that the specified device for resident #004 was provided by the resident's SDM. The DOC indicated that since resident would not be able to cognitively or physically remove the device, it would be considered as a restraint. The DOC agreed with the inspector that the use of the specified restraint device for resident #004 would be considered as prohibited devices that limits the resident's movements. [s. 112.]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 083)
The following order(s) have been rescinded:CO# 002

Issued on this 24 day of April 2018 (A1)(Appeal/Dir# DR# 083)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by KAREN SIMPSON (Director) - (A1) (Appeal/Dir# DR# 083)

Inspection No. / No de l'inspection : 2018_593573_0001 (A1)(Appeal/Dir# DR# 083)

Appeal/Dir# / Appel/Dir#: DR# 083 (A1)

Log No. / No de registre : 015049-17 (A1)(Appeal/Dir# DR# 083)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Apr 24, 2018;(A1)(Appeal/Dir# DR# 083)

Licensee / Titulaire de permis : The Governing Council of the Salvation Army in Canada
2 Overlea Blvd, TORONTO, ON, M4H-1P4

LTC Home / Foyer de SLD : The Salvation Army Ottawa Grace Manor
1156 Wellington Street, OTTAWA, ON, K1Y-2Z3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Roy Snow

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 The Governing Council of the Salvation Army in Canada, 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_593573_0013, 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 is hereby ordered to complete the following:

1. Amend the home's existing "Individual Assessment Form - Bed Rail Use" to include all relevant questions and guidance, as per the 2003 FDA Clinical Guidance document. The amended assessment form shall include resident's diagnosis, the resident's ability to toilet self safely and communication abilities.

2. Revise the resident assessment process related to bed rail use to ensure the interdisciplinary team of assessors documents a risk benefit assessment prior to the determination that beds rails are indicated for use for a resident, as per the 2003 FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings".

3. As per the 2003 FDA Clinical Guidance document, the risk benefit assessment, which is to be documented within the resident health care record, shall provide for the following:
a) Assessment of the relative risk associated with use or non-use of bedrails to the benefits for an individual resident.
b) Identification of why other care interventions are not appropriate, or not effective if they were previously attempted, and determined not to be the treatment of choice for the resident.

4. Reassess all residents with one or more bed rails in use in accordance with the revised assessment process, using the amended "Individual Assessment Form - Bed Rail Use". Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team.

5. Develop and implement a documented ongoing auditing process to ensure that all requirements of this compliance order are satisfied.

Grounds / Motifs :

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

On August 30, 2017, the licensee was served with a compliance order pursuant to O.

Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_593573_0013. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance.

The compliance order due date was November 22, 2017.

Parts 1, 4 and 5 of the compliance order were related to evaluation of resident's bed system with bed rails and parts 2 to 3 of the compliance order were related to the assessment of residents. The parts of the compliance order that have not been complied with will be referenced and addressed below.

Part 2 and part 3 of the compliance order required the licensee to take the following actions:

2. Ensure that an interdisciplinary team assess all residents in the home who use any type of bed rails, in accordance with the 2003 FDA prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings". The assessment shall include the assessment of the relative risk of using the bed rails compared with not using them for an individual resident. The assessment is to occur before a decision to use or to discontinue the use of a bed rail is made.

3. Ensure that the above assessments are documented including the names of team members participating in the assessment, the results of the assessment including the risk benefit assessment, and the recommendations.

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008" (HC guidance document). In the memo, it is indicated that the Ministry expects homes to use the HC Guidance Document as a best practices document in their home.

The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States.

The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is specified that any decision to use or to discontinue use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. Numerous factors are to be considered and are specified.

The process is to result in a documented risk benefit assessment, prior to the team's conclusion that bed rails may be indicated for use. Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:
a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.
b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the resident.
c) Comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident.

The 2003 FDA Clinical Guidance document specifies that where clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On January 12, 2018, during an interview, the home's DOC indicated to the Inspector that the licensee uses an "Individual Assessment Form - Bed Rail Use" to evaluate all residents in the home who use any type of bed rails. Further, she indicated that the resident individual assessment form was to be completed with an interdisciplinary team.

On January 15, 2018, Inspector #573 observed resident #002 and #004's bed system, both bed systems were noted to have two bed rails in the up position. It was confirmed through observation and staff interviews that the bed rails were used for the above identified residents.

Inspector #573 reviewed resident #002 and #004's health care records and the Individual Assessment Form - Bed Rail Use.

Resident #002 was admitted to the home on an identified date, with multiple diagnosis. Resident's health care records indicated that resident #002 was at risk for falls. Further, the resident's written current plan of care identified the use of two ¼ bed rails to provide assistance with bed mobility.

Resident #004 was admitted to the home on an identified date, with multiple diagnosis. Resident's health care records related to resident's diagnosis, indicated that resident #004 was at risk of falling out of bed and at risk for injury. The resident's current written plan of care identified the use of two 1/2 padded bed rails as a restraint and further identified the bed rails were not used for bed mobility.

Upon review of resident #002 and #004's Individual Assessment Form Bed Rail Use, the Inspector noted that the form does not include the resident "diagnosis" and there were no questions related to resident's ability to "toilet self safely" and "communication". The Inspector noted that the form did not appear to provide for the documentation of a risk benefit assessment as per the 2003 FDA Clinical Guidance document. Resident #002 and #004's Individual Assessment Form Bed Rail Use identified multiple risk factors. For resident #002, in the Individual Assessment Form Bed Rail Use under, recommendations, it was indicated that side rails were recommended due to resident's SDM being fearful of resident's falls. For resident #004, the individual assessment form bed rail use, indicated that the resident needed bed rails for mobility. Whereas resident #004's written plan of care in place indicated the bed rails were not used for bed mobility. Upon further review, Inspector noted that the assessment process failed to provide any information regarding how the benefits outweigh the risk of entrapment for the resident. The assessment process does not provide for the determination of relative risk of using bed rails compared with not using them for the resident. The assessment form does include the other interventions that were tried but does not identify why other care interventions were not appropriate or effective if attempted. The assessment process does not document a risk-benefit assessment that demonstrates that clinical and

environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or that a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them.

On January17, 2018, Inspector #573 met with the home's DOC and ADOC. Following discussion about the Individual Assessment Form Bed Rail Use, both the DOC and ADOC indicated that the assessment form does not include the resident diagnosis and there were no questions related to resident's ability to toilet self safely and communication. Regarding the notion of risk benefit assessment as per the 2003 FDA Clinical Guidance document, the DOC and ADOC indicated that the assessment form does not provide for a documented risk benefit assessment, and also indicated that documented risk benefit assessment was not being captured elsewhere within the resident's health care records.

In summary, the licensee has failed to comply with all aspects of Compliance Order #001, issued as a result of Resident Quality Inspection #2017_593573_0013. As a result of the continuing widespread non-compliance, which presents the potential for actual harm, a subsequent Compliance Order will be served to the licensee. (573)

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

Apr 30, 2018

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

(A1)(Appeal/Dir# DR# 083)
The following Order has been rescinded:

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 112. For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 24 day of April 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by KAREN SIMPSON (Director) - (A1)
(Appeal/Dir# DR# 083)

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

Service Area Office / Bureau régional de services : Ottawa