Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 25, 2018	2018_539120_0018	024836-17	Other

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

Upper Canada Lodge
272 Wellington Street P.O. Box 1390 NIAGARA-ON-THE-LAKE ON L0S 1J0

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): April 11, 12, 24, 2018

A Resident Quality Inspection (2017-700536-0018) was previously conducted on conducted October 24-30, 2017, at which time the inspectors suspected that the licensee's bed safety program was not developed in accordance with prevailing practices and referred the matter to inspector #120 for further review.

During the course of the inspection, the inspector(s) spoke with Administrator, Clinical Director of Resident Care, Director of Resident Care, registered staff, personal support workers and residents.

During the course of the inspection, the inspector toured several home areas, reviewed resident clinical records and bed safety policies and procedures.

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Prevailing Practices

A companion guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration) provides the necessary guidance in establishing a clinical assessment where bed rails are used. An additional companion guide titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006" provides the necessary guidance in purchasing bed systems, implementing quality monitoring and selecting and using appropriate accessories for specific risk areas. Both guides are cited in a document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008" and was identified by the Director of the Ministry of Health and Long Term Care in 2012, as the prevailing practices with respect to bed safety.

According to the Clinical Guidance document, "in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape". The definition of a bed rail is "an adjustable metal or rigid plastic bar that attaches to the bed, that are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths". Once bed rails are applied and made available for use, residents would need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to

establish risk-related hazards associated with one or more bed rails. The risk-related hazards include but are not limited to strangulation, suffocation, bruising or injury against the bed rail, suspension, entanglement and entrapment. The Clinical Guidance document emphasizes the importance of establishing procedures/processes as to who would monitor the residents, for how long and at what frequency, the specific hazards that would need to be monitored while the resident was in bed with one or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails were available.

Licensee Policies and Procedures in Conducting Resident Assessments

The procedure or policy that was developed to guide the registered staff in completing their assessments was titled "Bed Rail Risk Assessment, (RKM00-025)", last revised April 2016. It referenced the above noted Clinical Guidance document, provided the name of the form to use, the frequency of completing the assessment, when to complete it (i.e. upon admission, change to existing rails), if bed rails are required, and that the results are included in the plan of care. The procedure did not include any information about how to determine if bed rails were a safety risk for the resident, the types of safety risks, how to mitigate any identified safety risks (and what available accessories and supplies were available for the various types of risks) and the use of available alternatives. According to the Administrator, interviewed on the second date of inspection, the policy was not developed to be detailed and it was the expectation that the registered staff knew how to conduct an assessment based on their training and knowledge and could refer to the Clinical Guidance document if needed.

The form that was used by registered staff to complete their assessments was titled "Bed Rail Risk Assessment - V1" and included five relevant questions related to the resident that could potentially increase their risk of a bed rail-related injury. The questions included the resident's state of mind (whether confused, agitated, distressed, cognitively impaired), whether they had involuntary body movements, altered sensations, were at risk of climbing over the bed rails and if the resident needed to get out of bed unsupervised. The remaining questions required the RN to decide what alternative(s) to bed rails could be trialled and the risks or benefits of the alternative(s) and what the key factors were for or against prescribing bed rails.

Resident Assessment Process

According to Registered Nurse (RN) #001 and the Clinical Director of Care on the first

date of inspection, the bed systems in the home were once equipped with three-quarter length bed rails and were removed and replaced with assist rails or quarter length bed rails several years prior. It was in their opinion that once the longer bed rails were removed and replaced with shorter bed rails, the risk for bed entrapment was removed or mitigated and that the bed rails were not a restraint. Neither staff member was aware of the specific risks associated with the shorter quarter length bed rails or the assist rails which were approximately 18 inches in width and located near the centre of the bed along the frame.

According to RN# 001 on the first date of inspection and, who completed many of the resident assessments, including two that were reviewed, the process of observing the resident while in bed after bed rails were applied specifically for entrapment, soft tissue injury, entanglement or suspension risks were not conducted. The form noted above was completed before residents (new admissions) spent one night in bed. The answers to the five questions were answered by the resident themselves or by their Substitute Decision Maker (SDM) without confirmation through independent observation of the resident interacting with their bed system while in bed and asleep. RN #001, when asked if they were familiar with the contents of the Clinical Guidance document revealed that they were not, but had some knowledge regarding bed related hazards. Questions related to the resident`s behaviour and medical diagnosis while in bed sleeping or resting were not included in the bed rail assessment. The Clinical Guidance document recommends that due to the differing factors for each resident, in order to establish a good understanding of the risk-benefit assessment (that the risk of bed rail use is lower than that of other interventions or of not using them) that the individual resident assessment include but not be limited to continence habits, sleep disorders, comfort, communication, risk of falling, mobility in and out of bed, sleeping environment, amount of support by caregivers, medical stabilization interventions and strategies and other factors.

According to RN #001, RPN #006 and the Clinical Director of Care on the second date of inspection, the admission of residents as per their "Admission Check List" required them to complete the bed rail assessment on day one. The residents were therefore not observed specifically for bed rail associated hazards after they were applied and their sleep patterns and other behaviours and habits were not included in the bed rail assessment process.

The assessment process was determined to be missing several components or processes in identifying the risk over the benefits of bed rail use for residents using one

or more bed rails. The first being the absence of an independent sleep observation period before and after bed rails were applied in order to establish whether an alternative would be beneficial over the use of a bed rail, and secondly, if a bed rail was applied, the risks or hazards associated with them. Secondly, the assessment failed to include the names of an interdisciplinary team of individuals who were involved in observing and assessing the resident for behaviours, sleep patterns etc. The home's Physiotherapist and Physiotherapy Assistant, who determined resident's abilities for transfers and other abilities were not involved in any bed safety assessments. The names of the PSWs who were assigned to care for specific residents and who had knowledge about the resident's behaviours, sleep patterns and habits and could have contributed to the overall assessment, were not included. According to the Clinical Guide, team members can include the physician, personal support workers, physiotherapist, rehabilitation workers, occupational therapists, family members, dietary personnel etc. Thirdly, a selection of possible alternatives (bolsters or soft rails) and accessories was not made readily available to registered staff, who were unaware of the options available in the market place for the replacement of bed rails or to mitigate certain identified risks.

Resident Assessments

Three residents ((#100, #101, #103) were randomly selected during this inspection to determine if they were assessed for bed rail-related safety risks in accordance with the Clinical Guidance document noted above. All three residents had a written plan of care identifying that they required one or more assist or quarter length side rails up at all times while in bed.

1. Resident #100 was observed in bed on the second day of inspection, after lunch with two assist rails in place. A review of the resident's clinical records revealed that the resident was admitted to the home in 2016, and was assessed on the same day by an RN who documented that the resident required one assist rail, and several days later, was re-assessed to require two assist rails. The assessment included information that the resident requested the rails and required them for bed mobility. The assessment form did not include information as to whether alternatives were trialled and no independent sleep observation conclusions, information about the resident's sleep habits and patterns, behaviours or ability to use the bed rails independently or safely. The assessment form included that the resident had several risk factors that predisposed them to an increased risk of bed rail related injury identified on both October 2016 assessments. The RN had no concerns related to these risks. No re-assessments were completed in 2017 or 2018.

The resident's written plan of care included additional information regarding bed safety related factors that were not listed on the bed rail risk assessment.

According to the resident's clinical record (Minimum Data Set), the resident's physical functioning was assessed in January 2018, and required assistance with their bed mobility. The information was added to the written plan of care in January 2017. The resident's PSW #010, who was asked about the residents bed mobility confirmed that the resident required assistance with bed mobility and used the bed rails with staff supervision.

Based on the information provided, the resident's risk factors appeared to have outweighed the benefits of bed rail use and since the initial bed rail risk assessment, it appeared that the resident's condition related to bed mobility changed.

2. Resident #101 was interviewed on the second day of inspection regarding the two assist rails applied to their bed. The resident stated that they used them to get in and out bed and for repositioning. The resident's clinical record revealed that the resident was admitted in June 2017, and had a bed rail risk assessment completed the following day. No risk factors were selected by the RN who completed the assessment. Another bed rail risk assessment was completed in January 2018, and the RN documented that the resident had an identified risk factor related to bed entrapment or injury and that the resident requested bed rails on both assessments for transfers and repositioning. Two quarter length bed rails were selected for use. The RN made a note on both assessments that alternatives were not trialled and that they had no concerns about risks of bed rail use. No independent sleep observation conclusions were documented such as information about the resident's sleep habits and patterns, behaviours or ability to use the bed rails independently or safely.

The resident's written plan of care included additional information regarding bed safety related factors that were not included on the bed safety assessment. The plan included the need to have two quarter length bed rails up at all times when in bed that was dated June 2017.

Based on the information provided, the resident's bed rails were either incorrectly labelled or the resident received new bed rails after January 2018. The resident's risk factors appeared to have outweighed the benefits of bed rail use.

3. Resident #103 was not observed in bed at the time of inspection, however, both of their quarter length bed rails were elevated or raised. A review of the resident's clinical record revealed that the resident was admitted to the home in January 2016, and had a bed rail risk assessment completed on the same date. The RN documented that the resident had an identified risk factor related to bed entrapment or injury and that the resident requested the bed rails. Two quarter length bed rails were selected for use and no reason for use was included. According to the resident's progress notes, three additional assessments were completed, January 2018, and two in April 2018. Each of the assessments included information that the resident had two assist rails in place. No independent sleep observation conclusions were documented on any of the assessments, such as information about the resident's sleep habits and patterns, behaviours or ability to use the bed rails independently or safely.

The resident's written plan of care included additional information regarding bed safety related factors that were not included on the bed safety assessment.

The resident's PSW #009, who was asked about the residents bed mobility confirmed that the resident required assistance with transfers and bed mobility and used the bed rails with staff supervision.

Based on the information provided, the resident's bed rails were incorrectly labelled and the resident's risk factors appeared to have outweighed the benefits of bed rail use. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 4th day of June, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2018_539120_0018
Log No. / No de registre :	024836-17
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	May 25, 2018
Licensee / Titulaire de permis :	The Regional Municipality of Niagara 1815 Sir Isaac Brock Way, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	Upper Canada Lodge 272 Wellington Street, P.O. Box 1390, NIAGARA-ON-THE-LAKE, ON, L0S-1J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Margaret Lambert

To The Regional Municipality of Niagara, 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)

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 the LTCHA.

Specifically, the licensee shall complete the following;

1. Amend the home's existing "Bed Rail Risk Assessment " form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003). This document is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The amended questionnaire shall, at a minimum, include:
a) questions that can be answered by the assessors related to the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to and after the application of any bed rails; and
b) the alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the specified period of use or if no alternatives were trialled, document why they were not trialled; and

c) include the names of the interdisciplinary team members who participated in assessing the resident.

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

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

4. Obtain or develop an education and information package that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.

5. Amend the "Bed Rail Risk Assessment (RKM00-025)" policy to include requirement #1 and #2 noted above, the role of the select interdisciplinary members involved in the resident assessments, the available alternatives to bed rails and the accessories that are available to mitigate any identified risks or hazards.

6. Registered staff who complete the bed rail risk assessments shall have knowledge of the contents of the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) and the "Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, (U.S. F.D.A, 2006)".

7. All registered and non-registered staff shall be informed about the amended policy, forms and procedures.

Grounds / Motifs :

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

Prevailing Practices

A companion guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration) provides the necessary guidance in establishing a clinical assessment where bed rails are used. An additional companion guide titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006" provides the necessary guidance in purchasing bed systems, implementing quality monitoring and selecting and using appropriate accessories for specific risk areas. Both guides are cited in a document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008" and was identified by the Director of the Ministry of Health and Long Term Care in 2012, as the prevailing practices with respect to bed safety.

According to the Clinical Guidance document, "in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape". The definition of a bed rail is "an adjustable metal or rigid plastic bar that attaches to the bed, that are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths". Once bed rails are applied and made available for use, residents would need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk-related hazards associated with one or more bed rails. The risk-related hazards include but are not limited to strangulation, suffocation, bruising or injury against the bed rail, suspension, entanglement and entrapment. The Clinical Guidance document emphasizes the importance of establishing procedures/processes as to who would monitor the residents, for how long and at what frequency, the specific hazards that would need to be monitored while the resident was in bed with one or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails were available.
Licensee Policies and Procedures in Conducting Resident Assessments

The procedure or policy that was developed to guide the registered staff in completing their assessments was titled "Bed Rail Risk Assessment, (RKM00-025)", last revised April 2016. It referenced the above noted Clinical Guidance document, provided the name of the form to use, the frequency of completing

the assessment, when to complete it (i.e. upon admission, change to existing rails), if bed rails are required, and that the results are included in the plan of care. The procedure did not include any information about how to determine if bed rails were a safety risk for the resident, the types of safety risks, how to mitigate any identified safety risks (and what available accessories and supplies were available for the various types of risks) and the use of available alternatives. According to the Administrator, interviewed on the second date of inspection, the policy was not developed to be detailed and it was the expectation that the registered staff knew how to conduct an assessment based on their training and knowledge and could refer to the Clinical Guidance document if needed.

The form that was used by registered staff to complete their assessments was titled "Bed Rail Risk Assessment - V1" and included five relevant questions related to the resident that could potentially increase their risk of a bed rail-related injury. The questions included the resident's state of mind (whether confused, agitated, distressed, cognitively impaired), whether they had involuntary body movements, altered sensations, were at risk of climbing over the bed rails and if the resident needed to get out of bed unsupervised. The remaining questions required the RN to decide what alternative(s) to bed rails could be trialled and the risks or benefits of the alternative(s) and what the key factors were for or against prescribing bed rails.

Resident Assessment Process

According to Registered Nurse (RN) #001 and the Clinical Director of Care on the first date of inspection, the bed systems in the home were once equipped with three-quarter length bed rails and were removed and replaced with assist rails or quarter length bed rails several years prior. It was in their opinion that once the longer bed rails were removed and replaced with shorter bed rails, the risk for bed entrapment was removed or mitigated and that the bed rails were not a restraint. Neither staff member was aware of the specific risks associated with the shorter quarter length bed rails or the assist rails which were approximately 18 inches in width and located near the centre of the bed along the frame.

According to RN# 001 on the first date of inspection and, who completed many of the resident assessments, including two that were reviewed, the process of observing the resident while in bed after bed rails were applied specifically for

entrapment, soft tissue injury, entanglement or suspension risks were not conducted. The form noted above was completed before residents (new admissions) spent one night in bed. The answers to the five questions were answered by the resident themselves or by their Substitute Decision Maker (SDM) without confirmation through independent observation of the resident interacting with their bed system while in bed and asleep. RN #001, when asked if they were familiar with the contents of the Clinical Guidance document revealed that they were not, but had some knowledge regarding bed related hazards. Questions related to the resident`s behaviour and medical diagnosis while in bed sleeping or resting were not included in the bed rail assessment. The Clinical Guidance document recommends that due to the differing factors for each resident, in order to establish a good understanding of the risk-benefit assessment (that the risk of bed rail use is lower than that of other interventions or of not using them) that the individual resident assessment include but not be limited to continence habits, sleep disorders, comfort, communication, risk of falling, mobility in and out of bed, sleeping environment, amount of support by caregivers, medical stabilization interventions and strategies and other factors.

According to RN #001, RPN #006 and the Clinical Director of Care on the second date of inspection, the admission of residents as per their "Admission Check List" required them to complete the bed rail assessment on day one. The residents were therefore not observed specifically for bed rail associated hazards after they were applied and their sleep patterns and other behaviours and habits were not included in the bed rail assessment process.

The assessment process was determined to be missing several components or processes in identifying the risk over the benefits of bed rail use for residents using one or more bed rails. The first being the absence of an independent sleep observation period before and after bed rails were applied in order to establish whether an alternative would be beneficial over the use of a bed rail, and secondly, if a bed rail was applied, the risks or hazards associated with them. Secondly, the assessment failed to include the names of an interdisciplinary team of individuals who were involved in observing and assessing the resident for behaviours, sleep patterns etc. The home's Physiotherapist and Physiotherapy Assistant, who determined resident's abilities for transfers and other abilities were not involved in any bed safety assessments. The names of the PSWs who were assigned to care for specific residents and who had knowledge about the resident's behaviours, sleep patterns and habits and could have contributed to the overall assessment, were

not included. According to the Clinical Guide, team members can include the physician, personal support workers, physiotherapist, rehabilitation workers, occupational therapists, family members, dietary personnel etc. Thirdly, a selection of possible alternatives (bolsters or soft rails) and accessories was not made readily available to registered staff, who were unaware of the options available in the market place for the replacement of bed rails or to mitigate certain identified risks.

Resident Assessments

Three residents ((#100, #101, #103) were randomly selected during this inspection to determine if they were assessed for bed rail-related safety risks in accordance with the Clinical Guidance document noted above. All three residents had a written plan of care identifying that they required one or more assist or quarter length side rails up at all times while in bed.

1. Resident #100 was observed in bed on the second day of inspection, after lunch with two assist rails in place. A review of the resident's clinical records revealed that the resident was admitted to the home in 2016, and was assessed on the same day by an RN who documented that the resident required one assist rail, and several days later, was re-assessed to require two assist rails. The assessment included information that the resident requested the rails and required them for bed mobility. The assessment form did not include information as to whether alternatives were trialled and no independent sleep observation conclusions, information about the resident's sleep habits and patterns, behaviours or ability to use the bed rails independently or safely. The assessment form included that the resident had several risk factors that predisposed them to an increased risk of bed rail related injury identified on both October 2016 assessments. The RN had no concerns related to these risks. No re-assessments were completed in 2017 or 2018.

The resident's written plan of care included additional information regarding bed safety related factors that were not listed on the bed rail risk assessment.

According to the resident's clinical record (Multiple Data Set), the resident's physical functioning was assessed in January 2018, and required assistance with their bed mobility. The information was added to the written plan of care in January 2017. The resident's PSW #010, who was asked about the residents bed mobility confirmed that the resident required assistance with bed mobility

and used the bed rails with staff supervision.

Based on the information provided, the resident's risk factors appeared to have outweighed the benefits of bed rail use and since the initial bed rail risk assessment, it appeared that the resident's condition related to bed mobility changed.

2. Resident #101 was interviewed on the second day of inspection regarding the two assist rails applied to their bed. The resident stated that they used them to get in and out bed and for repositioning. The resident's clinical record revealed that the resident was admitted in June 2017, and had a bed rail risk assessment completed the following day. No risk factors were selected by the RN who completed the assessment. Another bed rail risk assessment was completed in January 2018, and the RN documented that the resident had an identified risk factor related to bed entrapment or injury and that the resident requested bed rails on both assessments for transfers and repositioning. Two quarter length bed rails were selected for use. The RN made a note on both assessments that alternatives were not trialled and that they had no concerns about risks of bed rail use. No independent sleep observation conclusions were documented such as information about the resident's sleep habits and patterns, behaviours or ability to use the bed rails independently or safely.

The resident's written plan of care included additional information regarding bed safety related factors that were not included on the bed safety assessment. The plan included the need to have two quarter length bed rails up at all times when in bed that was dated June 2016.

Based on the information provided, the resident's bed rails were either incorrectly labelled or the resident received new bed rails after January 2018. The resident's risk factors appeared to have outweighed the benefits of bed rail use.

3. Resident #103 was not observed in bed at the time of inspection, however, both of their quarter length bed rails were elevated or raised. A review of the resident's clinical record revealed that the resident was admitted to the home in January 2016, and had a bed rail risk assessment completed on the same date. The RN documented that the resident had an identified risk factor related to bed entrapment or injury and that the resident requested the bed rails. Two quarter length bed rails were selected for use and no reason for use was included.

According to the resident's progress notes, three additional assessments were completed, January 2018, and two in April 2018. Each of the assessments included information that the resident had two assist rails in place. No independent sleep observation conclusions were documented on any of the assessments, such as information about the resident's sleep habits and patterns, behaviours or ability to use the bed rails independently or safely.

The resident's written plan of care included additional information regarding bed safety related factors that were not included on the bed safety assessment.

The resident's PSW #009, who was asked about the residents bed mobility confirmed that the resident required assistance with transfers and bed mobility and used the bed rails with staff supervision.

Based on the information provided, the resident's bed rails were incorrectly labelled and the resident's risk factors appeared to have outweighed the benefits of bed rail use.

This compliance order is based upon three factors where there has been a finding of non compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to s.15(1)(a) of O. Reg. 79/10, the severity of this issue was determined to be a level 2 as bed rails have a potential of causing harm to residents. The scope of the issue was a level 3, as residents who were not assessed in accordance with prevailing practices was widespread. The history of non-compliance is a level 2, as previous non-compliance was issued, but was not related to this section.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 25th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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