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 # / Registre no	Type of Inspection / Genre d'inspection
Jan 24, 2017	2016_539120_0081	020549-16	Follow up

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

WELLINGTON PARK CARE CENTRE
802 HAGER AVENUE BURLINGTON ON L7S 1X2

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 27 & 29, 2016

An inspection (2016-240506-0006) was previously conducted in April 2016 at which time an order was issued related to the home's bed safety program. For this follow-up inspection, the conditions laid out in the order were not fully complied with and the order is being re-issued.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC) and registered staff.

During the course of the inspection, the inspector toured the 2nd floor, observed residents' bed systems, reviewed bed safety policies and procedures, clinical bed safety assessments and resident's clinical records.

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

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, the residents were assessed and that resident's beds were evaluated in accordance with prevailing practices to minimize risk to the resident.

Resident Assessments

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

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of

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

For this follow up inspection, four residents (#100-103) were selected for review to determine whether they were assessed for bed rail safety in accordance with the Clinical Guidance document above. Residents #100 and #102 were observed in bed with one or more bed rails in use and had a written plan of care identifying that they required one or more bed rails in a particular position (either in "guard" or "assist" positions) and resident #101 did not require the use of bed rails but was provided with a bolstered mattress. Resident #103 was provided with a bolstered mattress and had both rotating assist rails in the "assist" position.

According to registered staff, all four residents were assessed by registered staff and monitored by personal support workers (PSWs) for three days regarding the use of their bed rails and sleeping patterns. The results were electronically entered into a database which was used by registered staff to complete other assessment forms. A total of four different types of forms were reviewed and whether in combination or alone, did not fully capture enough or adequate bed safety information identified in the Clinical Guidance document noted above. The forms were geared towards the use of various types of Personal Assistance Services Devices (PASD) and bed rails were included as one type of PASD. The licensee did not develop any policies or procedures for the various staff members in the home to follow in conducting clinical bed safety assessments and did not

identify what forms were to be consistently used and when.

A) The licensee did not develop a form or data collection tool that was specifically designed to capture the assessor's decision making regarding the various risks related to the resident who had a bed rail applied, whether in the "guard" or "assist" position while in bed, especially when asleep. The form that was used captured limited information, related mostly to the resident's ability to use the bed rail for bed mobility and transfers out or into bed. The questions that were answered by the PSWs and who were tasked to observe the resident in bed were designed as "yes" and "no" questions. These included whether or not the resident slept during their shift, if they attempted to self-transfer, required bed rails to reposition themselves, if they settled after being given a snack or after being toileted. Three relevant questions related to sleep behaviour were included which related to restlessness, if the resident slept near the edge of the bed or traveled to the four corners of the bed. The data collected did not include whether other factors related to bed safety as identified in the Clinical Guidance document were considered such as the resident's cognition status, medication use, signs of pain or discomfort, whether the resident fell from bed (during the observation or before coming to the home), acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail, had altered sensations, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely, if they were at risk of climbing over the bed rails, their sleeping characteristics (or sleeping disorders) and any other habits and behaviours. According to registered staff who were involved in the bed safety program, at the conclusion of the three-day observation of the residents, the data collected by the PSWs was reviewed and a decision made regarding whether a bed rail would be applied for resident use. For newly admitted residents since April 2016, bed rails were not automatically applied until a need was established. For residents who were already in the home prior to April 2016 and were already using bed rails, some were re-assessed and bed rails removed or alternatives provided (bolstered mattress), however more than 50% of the residents had not been re-assessed at the time of the inspection and assessments were on-going.

B) Several forms were noted to have been completed by registered staff regarding the use of bed rails for individual residents, however not every resident had each type of form completed. A form titled "Interdisciplinary PASD Assessment and Consent" (IPAC) form was used by registered staff to document what alternatives were trialled for each resident before attempting to use the hard bed rail. However, the form was not designed to include relevant reasons for bed rail use and did not include written comments as to what exactly was trialled, when, for how long and whether the alternative(s) was

successful or not. The list of alternatives on the form were extensive and included some related and some unrelated interventions for alternatives to bed rails such as walking program, pain management, nourishment/fluids, OT/PT, one to one care, falls interventions, modifications to environment, room change, equipment, sitter at bedside, sensory aids, positioning, regular toileting, diversional activities, medication review and behaviour management. According to the Clinical Guidance document, the use of "perimeter reminders" or "border definers" such as body pillow/cushions/bolsters(soft rails), mattresses with lipped/raised edges, bed alarms, hand grips and various monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. These particular accessories or modified equipment were not included as options on the form to better guide staff decision making, however these options were observed to be in use in the home. The IPAC form was not designed to include "repositioning" or "transfers" or "bed mobility" as reasons for bed rail use but instead listed options such as "prevent damage to environment", "prevent harm to self", "prevent harm to others" and "prevent disruption of treatment".

The "Quarterly Review for Use of PASD" (QRFUP) form listed the reason for the restraint (but did not include any relevant bed rail options), whether the PASD was effective (with a "yes" or "no" option), how the PASD affected the resident, a reason for the assessor's decision and the names of the team members who completed the review.

A Non-triggered Clinical Rap (NTCR) form also used by registered staff included the type of PASD, nature of the resident's condition, key issues and care planning decisions.

For resident #100, no IPAC form, QRFUP form, progress notes or NTCR form was provided for review when requested regarding the use of the resident's bed rail. The resident was observed with one bed rail in the "assist" position during the inspection on both December 27 and December 29, 2016. The resident's written plan of care identified that the resident required the bed rail for transfers. Therefore the risks associated with the resident and their bed system were unknown.

For resident #102, all four forms were provided for review. The QRFUP form was dated April 2016, the IPAC form was dated August 2015 and the NTCR form was dated January 2015. The resident was observed to be in bed on both December 27 and December 29, 2016 with both bed rails in the "guard" position. The resident's written plan of care identified that the resident did not like the bolstered mattress and wanted the bed rails available for bed mobility. The resident has had the bed rails in place since

2011. None of the forms identified above included what risk factors were considered in deciding whether hard bed rails were the best option for the resident and if risk factors were identified, what interventions were trialled to mitigate the risk.

Resident #103 was observed to have soft bolsters attached to their mattress on each side and also had both bed rails in the "assist" position. According to the resident's clinical record (progress notes), the resident has had two bed rails in use since 2011. In March and September 2016, the resident was re-assessed and continued to require two bed rails and a request for a bolstered mattress made in May 2016, however another request for a bolstered mattress was made in September 2016. These assessments were not available for review to determine if any safety factors were taken into consideration. The last fully completed assessment form that was provided for review included the IPAC form dated September 2015. This particular form did not adequately identify what was trialled or the reason for the two bed rails. The answers included "other" for alternative trialled with a note that the resident had a particular health condition and requested bed rails for safety and security and the reason identified for bed rail use included the term "comfort" and identified the health condition.

Bed Evaluations

The licensee was required to re-evaluate all of their beds according to the order issued on April 27, 2016. During this inspection, confirmation was made that all beds were not re-evaluated in 2016. In 2015, the licensee evaluated all of their beds in accordance with Health Canada (HC) Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006" and identified that all of the beds passed entrapment zones 1 through 4. According to the Administrator and the licensee's policy E05-05, re-evaluations of the bed systems in 2016 were limited to those beds where residents received a new or different bed rail or a new mattress and where bed systems were re-assigned to a different resident. The licensee's policy E05-05 regarding bed system evaluations included some references similar to those in the HC Guidelines as to when to evaluate the bed systems, such as "when surfaces or a bed rail were changed" and when "issues arise that could affect the condition of bed rails and mattresses". The HC Guidelines identified the need to liaise with both the bed manufacturer and mattress manufacturers (if ordered separately from the bed manufacturer) to establish bed system evaluation frequencies. Frequency of evaluating both mattresses and bed frames would depend on multiple factors which are identified by the manufacturers' of the products. The policy did not include any additional information

describing what types of bed rail and mattress conditions would warrant a re-evaluation of the bed system and how the beds would all be monitored for these conditions and other safety issues such as latch reliability, sharp edges, hydraulic or electrical failure, overheating of motors, mattress type, rail height from the top of the mattress, use of overlays and bed accessories on an on-going basis. During the inspection, one bed was identified on 2W that did not have the same mattress that was identified during the evaluation. According to bed system evaluation records, each bed frame and mattress was labeled to ensure that they remained together once the bed system was measured, a process promoted by the HC Guidelines but was not identified in the licensee's policy.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and 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.

Additional Required Actions:

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

Issued on this 9th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2016_539120_0081
Log No. / Registre no:	020549-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 24, 2017
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	WELLINGTON PARK CARE CENTRE 802 HAGER AVENUE, BURLINGTON, ON, L7S-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Nevills

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_240506_0006, CO #001;

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing forms related to Personal Assistance Services Device evaluations or create a new form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and
c. the resident while sleeping for a specific period of time to establish risks to the resident after a bed rail has been applied and deemed necessary where an alternative was not successful; and
2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form and document the assessed results and recommendations for each resident.
3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.
4. Develop a policy and procedure that will guide an assessor in completing a clinical bed safety assessment in accordance with the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" and implement the policy.
5. Develop a policy and procedure that will guide an assessor in completing an evaluation of a bed system in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006" and implement the policy.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, the residents were assessed and that resident's beds were evaluated in accordance with prevailing practices to minimize risk to the resident.

Resident Assessments

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assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this follow up inspection, four residents (#100-103) were selected for review to determine whether they were assessed for bed rail safety in accordance with the Clinical Guidance document above. Residents #100 and #102 were observed in bed with one or more bed rails in use and had a written plan of care identifying that they required one or more bed rails in a particular position (either in "guard" or "assist" positions) and resident #101 did not require the use of bed rails but was provided with a bolstered mattress. Resident #103 was provided with a bolstered mattress and had both rotating assist rails in the "assist" position.

According to registered staff, all four residents were assessed by registered staff and monitored by personal support workers (PSWs) for three days regarding the use of their bed rails and sleeping patterns. The results were electronically entered into a database which was used by registered staff to complete other assessment forms. A total of four different types of forms were reviewed and whether in combination or alone, did not fully capture enough or adequate bed safety information identified in the Clinical Guidance document noted above. The forms were geared towards the use of various types of Personal Assistance Services Devices (PASD) and bed rails were included as one type of PASD. The licensee did not develop any policies or procedures for the various staff members in the home to follow in conducting clinical bed safety assessments and did not identify what forms were to be consistently used and when.

A) The licensee did not develop a form or data collection tool that was specifically designed to capture the assessor's decision making regarding the various risks related to the resident who had a bed rail applied, whether in the "guard" or "assist" position while in bed, especially when asleep. The form that was used captured limited information, related mostly to the resident's ability to use the bed rail for bed mobility and transfers out or into bed. The questions that were answered by the PSWs and who were tasked to observe the resident in bed were designed as "yes" and "no" questions. These included whether or

not the resident slept during their shift, if they attempted to self-transfer, required bed rails to reposition themselves, if they settled after being given a snack or after being toileted. Three relevant questions related to sleep behaviour were included which related to restlessness, if the resident slept near the edge of the bed or traveled to the four corners of the bed. The data collected did not include whether other factors related to bed safety as identified in the Clinical Guidance document were considered such as the resident's cognition status, medication use, signs of pain or discomfort, whether the resident fell from bed (during the observation or before coming to the home), acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail, had altered sensations, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely, if they were at risk of climbing over the bed rails, their sleeping characteristics (or sleeping disorders) and any other habits and behaviours. According to registered staff who were involved in the bed safety program, at the conclusion of the three-day observation of the residents, the data collected by the PSWs was reviewed and a decision made regarding whether a bed rail would be applied for resident use. For newly admitted residents since April 2016, bed rails were not automatically applied until a need was established. For residents who were already in the home prior to April 2016 and were already using bed rails, some were re-assessed and bed rails removed or alternatives provided (bolstered mattress), however more than 50% of the residents had not been re-assessed at the time of the inspection and assessments were on-going.

B) Several forms were noted to have been completed by registered staff regarding the use of bed rails for individual residents, however not every resident had each type of form completed. A form titled "Interdisciplinary PASD Assessment and Consent" (IPAC) form was used by registered staff to document what alternatives were trialled for each resident before attempting to use the hard bed rail. However, the form was not designed to include relevant reasons for bed rail use and did not include written comments as to what exactly was trialled, when, for how long and whether the alternative(s) was successful or not. The list of alternatives on the form were extensive and included some related and some unrelated interventions for alternatives to bed rails such as walking program, pain management, nourishment/fluids, OT/PT, one to one care, falls interventions, modifications to environment, room change, equipment, sitter at bedside, sensory aids, positioning, regular toileting, diversional activities, medication review and behaviour management. According to the Clinical Guidance document, the use of “perimeter reminders” or “border definers” such

as body pillow/cushions/bolsters(soft rails), mattresses with lipped/raised edges, bed alarms, hand grips and various monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. These particular accessories or modified equipment were not included as options on the form to better guide staff decision making, however these options were observed to be in use in the home. The IPAC form was not designed to include "repositioning" or "transfers" or "bed mobility" as reasons for bed rail use but instead listed options such as "prevent damage to environment", "prevent harm to self", "prevent harm to others" and "prevent disruption of treatment".

The "Quarterly Review for Use of PASD" (QRFUP) form listed the reason for the restraint (but did not include any relevant bed rail options), whether the PASD was effective (with a "yes" or "no" option), how the PASD affected the resident, a reason for the assessor's decision and the names of the team members who completed the review.

A Non-triggered Clinical Rap (NTCR) form also used by registered staff included the type of PASD, nature of the resident's condition, key issues and care planning decisions.

For resident #100, no IPAC form, QRFUP form, progress notes or NTCR form was provided for review when requested regarding the use of the resident's bed rail. The resident was observed with one bed rail in the "assist" position during the inspection on both December 27 and December 29, 2016. The resident's written plan of care identified that the resident required the bed rail for transfers. Therefore the risks associated with the resident and their bed system were unknown.

For resident #102, all four forms were provided for review. The QRFUP form was dated April 2016, the IPAC form was dated August 2015 and the NTCR form was dated January 2015. The resident was observed to be in bed on both December 27 and December 29, 2016 with both bed rails in the "guard" position. The resident's written plan of care identified that the resident did not like the bolstered mattress and wanted the bed rails available for bed mobility. The resident has had the bed rails in place since 2011. None of the forms identified above included what risk factors were considered in deciding whether hard bed rails were the best option for the resident and if risk factors were identified, what interventions were trialled to mitigate the risk.

Resident #103 was observed to have soft bolsters attached to their mattress on each side and also had both bed rails in the "assist" position. According to the resident's clinical record (progress notes), the resident has had two bed rails in use since 2011. In March and September 2016, the resident was re-assessed and continued to require two bed rails and a request for a bolstered mattress made in May 2016, however another request for a bolstered mattress was made in September 2016. These assessments were not available for review to determine if any safety factors were taken into consideration. The last fully completed assessment form that was provided for review included the IPAC form dated September 2015. This particular form did not adequately identify what was trialled or the reason for the two bed rails. The answers included "other" for alternative trialled with a note that the resident had a particular health condition and requested bed rails for safety and security and the reason identified for bed rail use included the term "comfort" and identified the health condition.

Bed Evaluations

The licensee was required to re-evaluate all of their beds according to the order issued on April 27, 2016. During this inspection, confirmation was made that all beds were not re-evaluated in 2016. In 2015, the licensee evaluated all of their beds in accordance with Health Canada (HC) Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006" and identified that all of the beds passed entrapment zones 1 through 4. According to the Administrator and the licensee's policy E05-05, re-evaluations of the bed systems in 2016 were limited to those beds where residents received a new or different bed rail or a new mattress and where bed systems were re-assigned to a different resident. The licensee's policy E05-05 regarding bed system evaluations included some references similar to those in the HC Guidelines as to when to evaluate the bed systems, such as "when surfaces or a bed rail were changed" and when "issues arise that could affect the condition of bed rails and mattresses". The HC Guidelines identified the need to liaise with both the bed manufacturer and mattress manufacturers (if ordered separately from the bed manufacturer) to establish bed system evaluation frequencies. Frequency of evaluating both mattresses and bed frames would depend on multiple factors which are identified by the manufacturers' of the products. The policy did not include any additional information describing what types of bed rail and mattress conditions would

warrant a re-evaluation of the bed system and how the beds would all be monitored for these conditions and other safety issues such as latch reliability, sharp edges, hydraulic or electrical failure, overheating of motors, mattress type, rail height from the top of the mattress, use of overlays and bed accessories on an on-going basis. During the inspection, one bed was identified on 2W that did not have the same mattress that was identified during the evaluation. According to bed system evaluation records, each bed frame and mattress was labeled to ensure that they remained together once the bed system was measured, a process promoted by the HC Guidelines but was not identified in the licensee's policy.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and 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 patient.

This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is widespread (3), where most of the residents in the home have not been assessed for bed safety in accordance with prevailing practices, the severity of the non-compliance has a potential to harm residents who use bed rails (2) and the history of non-compliance under s. 15(1) of Ontario Regulation 79/10 is on-going (4) with a VPC issued in February 2015 and an order issued in April 2016. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 17, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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