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
Jul 6, 2016	2016_189120_0037	013538-16	Critical Incident System

Licensee/Titulaire de permis

DELCARE LTC INC.
4800 DUFFERIN STREET TORONTO ON M3H 5S9

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

CAWTHRA GARDENS LIMITED PARTNERSHIP
590 Lolita Gardens MISSISSAUGA ON L5A 4N8

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): June 2, 3, 13, 2016

Critical Incident 2912-000007-16 related to resident injury and their bed system.

During the course of the inspection, the inspector(s) spoke with acting Administrator, the Director of Care, Environmental Services Manager and registered staff.

During the course of the inspection, the inspector toured random resident rooms, observed residents, reviewed bed safety policies and procedures and random resident clinical records related to bed safety assessments.

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, that residents were assessed in accordance with prevailing practices to minimize risk to the resident.

In May 2016, an identified resident became entangled in their 3/4 length bed rail which was located on the left side of their bed or the window side of their room. The resident's right leg was weaved in between the rungs of the bed rail (zone 1) and was lying on their back in the bed. The resident had a shoe on their right foot which was wedged under the lowest rung of the bed rail and the top of the mattress and a centre rung. The resident sustained minor bruising.

The resident, prior to the incident was assisted to bed by a staff member and their 3/4 length bed rail was raised on their left side (window side of the room) and their 1/4 length bed rail was raised on their right side (entry door side of the room). Shortly thereafter, the resident did not want to stay in bed and independently got out of bed and wandered along the corridors and was observed by staff out of the bed. Twenty minutes later a personal support worker noticed that the resident had become entangled in their bed rail and began the process of attempting to release the resident's leg with the assistance of registered staff. After 30 minutes, staff were not successful with the release and had to contact an external emergency service provider to assist.

According to the Director of Care and by reviewing available photos, it appeared that the resident become entangled trying to climb over the 3/4 length bed rail, either while in bed, by swinging their legs over the rails while seated on the bed or when trying to get into bed. In the photos, the resident was observed to be lying on their back, with the back

of their right knee resting over the top of the upper most horizontal rung of the bed rail and their right leg weaved around the mid horizontal rung with their foot (while wearing a shoe) wedged on top of the lowest horizontal rung and up against the vertical center rung. The left leg was resting on the upper most horizontal rung of the bed rail, with the shoe on the floor. The licensee made the decision to remove the 3/4 length bed rail post incident with the permission of the resident's Substitute Decision Maker (SDM). The documentation did not include whether or not the resident was included in the decision.

According to the resident's clinical record, the resident was fairly new to the home and required one person intermittent assistance with bed and chair transfers and could use the bed rails for repositioning. The resident's written plan of care dated the same date as the admission date, under the task of "Bed Rails" stated, "place both bed rails up (3/4 and 1/2) for turning and re-positioning when in bed as per family request. Resident is able to hold on to rails for positioning and transfer in/out of bed".

The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified below.

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 Guidance Document 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/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 (if next to a rail and along edge of bed) 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 (medical device). 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.

According to the Director of Care, the questionnaire used by herself and her registered staff included a form titled "Bed System Assessment" which was completed electronically (Point Click Care) for each resident. During the inspection, the "Bed System Assessment form" was reviewed and noted to have been completed for the identified resident and 5 other randomly selected residents, however the questions and processes identified in the Clinical Guidance document identified above were not fully incorporated into the process.

1. The assessment process did not incorporate a process by which the resident's sleep patterns, habits and behaviours could be evaluated or observed while sleeping in bed with or without the application of bed rails. The licensee's policy titled "Bed System Assessment" dated January 2016 directed registered staff to complete the assessment upon admission for new residents "prior to the resident being put to bed for their first night in the home" and did not direct staff to observe the residents for sleep patterns, habits or behaviours before completing the questions. According to the licensee's nursing consultant, registered staff were provided with education that an observation period be implemented, however the information was not in the policy. The licensee's assessment for the identified resident above was completed on the same date as

admission to the home. Based on information gathered from the resident, their SDM and a standard mobility test, the assessment concluded that the resident required a 3/4 length bed rail on their left and a quarter length bed rail on their right. No bed rail alternatives were considered prior to applying the bed rails and an independent review of the resident's sleeping habits and patterns before applying the bed rail was not conducted. According to the assessment, the resident was able to state their preference for the bed rail to "assist them with moving up in bed" and that their SDM was in agreement. The assessment included a section that was completed by the assessor indicating that both the resident and the SDM were "willing to accept the risks of strangulation, entrapment, entanglement, skin tears and bruising" if bed rails were to be used.

2. The assessment form did not include a section that could be completed by the assessor indicating what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. Examples included bed alarm, decreased time in bed, increased safety checks, call bell availability, hi/low bed and scheduled toileting. The options did not include bed rail alternatives such as a transfer pole, raised perimeter mattress (easier to grab than a flat mattress when being repositioned) or adjustable bolsters. For the above identified resident and the other randomly selected residents, it appeared that the bed rails were identified for bed mobility only. In these cases, the form did not clearly identify what options were discussed to minimize or eliminate the risks of strangulation, entrapment, entanglement, skin tears or bruising if bed rails were to be applied and considered to be more of a benefit than a risk.

3. The questions included on the assessment form did not include several key questions related to cognition and medication use. Relevant questions were noted to include resident overall mobility, falls history, bed rail use concerns such as a history of trying to climb out of bed when side rails were in place and if the resident had experienced any bed rail injuries or had become entangled in the past. However, when answered with either a "yes" or a "no", the form did not provide any direction to registered staff. The form included a question related to whether the resident was able to "state their preference about bed rails" and if the answer was "yes", the resident was required to answer whether they accepted the risks and if they were informed about the types of risk. The conclusion section of the assessment titled "Decision" did not include an option for the assessor to check that bed rails were "not recommended" and the reasons for the resident based on the outcomes of an observation period conducted by an interdisciplinary team of staff members. The registered staff member who completed

many of the resident assessments reported that the assessments were indeed completed quickly just after admission, were based on the answers provided by the SDM (if available) and resident (if capable) and that many questions could not be accurately answered without getting to know the resident better. In addition, the registered staff member and the Director of Care reported that they felt pressured by the SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation.

4. The assessment form did not specify what interdisciplinary staff members participated in the evaluation of the resident. The assessment forms reviewed included the name of the registered staff member only.

5. The written plan of care was reviewed for residents on the third floor after observing on June 3, 2016 one bed rail raised on beds in 12 different rooms. It appeared that the bed rails were left in the raised position out of staff habit. The raised bed rails were observed on the window side of each bed and in some cases covered by a blanket. No residents were observed in the beds at the time of observation. Discussion with the DOC revealed that staff were in some cases in 'the habit" of applying the bed rails and did not always follow the direction in the plan of care which identified that the bed rails be applied when the resident was in bed. According to the written plan of care for the above identified resident who became entangled, both bed rails were required to be raised when in bed. For resident #001 and #002, the plan of care stated that "2 bed rails were required for staff to provide instructions where to place hands on the bed rail for turning". With respect to the resident #003, the plan identified that the resident did not use the bed rails for any reason, yet both bed rails were required to be raised. According to the DOC, a number of residents had bed rails applied regardless of whether they could benefit from using them based on SDM request. In these cases, the term "safety" was included in the written plan of care as the reason for application. However, the term "safety" was not defined and was not included in the bed manufacturer's intended use instructions for the bed rail. It was not known what "safety" issues were being prevented by applying the bed rail.

This Order is being made based upon the application of three factors, (severity, scope and compliance history) in keeping with s.229(1) of the Long-Term Care Regulation 79/10. The severity of the non-compliance is 3 (actual harm), the scope of the non-

compliance is 3 (wide spread - many residents with bed rails applied without a comprehensive bed rail safety assessment), and the compliance history is 3 (similar non compliance in the same area). The non-compliance was previously issued on May 12, 2015 as a Voluntary Plan of Compliance. [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 14th day of July, 2016

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_189120_0037
Log No. / Registre no:	013538-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 6, 2016
Licensee / Titulaire de permis :	DELCARE LTC INC. 4800 DUFFERIN STREET, TORONTO, ON, M3H-5S9
LTC Home / Foyer de SLD :	CAWTHRA GARDENS LIMITED PARTNERSHIP 590 Lolita Gardens, MISSISSAUGA, ON, L5A-4N8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARY JANE GLASSCO

To DELCARE LTC INC., 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 complete the following:

1. Amend the home's existing "Bed System 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) 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 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.

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. An on-going monitoring process shall be established to ensure that all staff apply the bed rails as specified in the plan of care (i.e. when applied, how many).

5. Develop an education and information package for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails.

Grounds / Motifs :

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

In May 2016, an identified resident became entangled in their 3/4 length bed rail which was located on the left side of their bed or the window side of their room. The resident's right leg was weaved in between the rungs of the bed rail (zone 1) and was lying on their back in the bed. The resident had a shoe on their right foot which was wedged under the lowest rung of the bed rail and the top of the mattress and a centre rung. The resident sustained minor bruising.

The resident, prior to the incident was assisted to bed by a staff member and their 3/4 length bed rail was raised on their left side (window side of the room) and their 1/4 length bed rail was raised on their right side (entry door side of the room). Shortly thereafter, the resident did not want to stay in bed and independently got out of bed and wandered along the corridors and was observed by staff out of the bed. Twenty minutes later a personal support worker noticed that the resident had become entangled in their bed rail and began the process of attempting to release the resident's leg with the assistance of registered staff. After 30 minutes, staff were not successful with the release and had to contact an external emergency service provider to assist.

According to the Director of Care and by reviewing available photos, it appeared that the resident become entangled trying to climb over the 3/4 length bed rail, either while in bed, by swinging their legs over the rails while seated on the bed or when trying to get into bed. In the photos, the resident was observed to be lying on their back, with the back of their right knee resting over the top of the upper most horizontal rung of the bed rail and their right leg weaved around the mid horizontal rung with their foot (while wearing a shoe) wedged on top of the lowest horizontal rung and up against the vertical center rung. The left leg was resting on the upper most horizontal rung of the bed rail, with the shoe on the floor. The licensee made the decision to remove the 3/4 length bed rail post incident with the permission of the resident's Substitute Decision Maker (SDM). The documentation did not include whether or not the resident was included in the decision.

According to the resident's clinical record, the resident was fairly new to the home and required one person intermittent assistance with bed and chair transfers and could use the bed rails for repositioning. The resident's written

plan of care dated the same date as the admission date, under the task of "Bed Rails" stated, "place both bed rails up (3/4 and 1/2) for turning and re-positioning when in bed as per family request. Resident is able to hold on to rails for positioning and transfer in/out of bed".

The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified below.

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 Guidance Document 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/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 (if next to a rail and along edge of bed) 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 (medical device). 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.

According to the Director of Care, the questionnaire used by herself and her registered staff included a form titled "Bed System Assessment" which was completed electronically (Point Click Care) for each resident. During the inspection, the "Bed System Assessment form" was reviewed and noted to have been completed for the identified resident and 5 other randomly selected residents, however the questions and processes identified in the Clinical Guidance document identified above were not fully incorporated into the process.

1. The assessment process did not incorporate a process by which the resident's sleep patterns, habits and behaviours could be evaluated or observed while sleeping in bed with or without the application of bed rails. The licensee's policy titled "Bed System Assessment" dated January 2016 directed registered staff to complete the assessment upon admission for new residents "prior to the resident being put to bed for their first night in the home" and did not direct staff to observe the residents for sleep patterns, habits or behaviours before completing the questions. According to the licensee's nursing consultant, registered staff were provided with education that an observation period be implemented, however the information was not in the policy. The licensee's assessment for the identified resident above was completed on the same date as admission to the home. Based on information gathered from the resident, their SDM and a standard mobility test, the assessment concluded that the resident required a 3/4 length bed rail on their left and a quarter length bed rail on their right. No bed rail alternatives were considered prior to applying the bed rails and an independent review of the resident's sleeping habits and patterns before applying the bed rail was not conducted. According to the assessment, the resident was able to state their preference for the bed rail to "assist them

with moving up in bed" and that their SDM was in agreement. The assessment included a section that was completed by the assessor indicating that both the resident and the SDM were "willing to accept the risks of strangulation, entrapment, entanglement, skin tears and bruising" if bed rails were to be used.

2. The assessment form did not include a section that could be completed by the assessor indicating what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. Examples included bed alarm, decreased time in bed, increased safety checks, call bell availability, hi/low bed and scheduled toileting. The options did not include bed rail alternatives such as a transfer pole, raised perimeter mattress (easier to grab than a flat mattress when being repositioned) or adjustable bolsters. For the above identified resident and the other randomly selected residents, it appeared that the bed rails were identified for bed mobility only. In these cases, the form did not clearly identify what options were discussed to minimize or eliminate the risks of strangulation, entrapment, entanglement, skin tears or bruising if bed rails were to be applied and considered to be more of a benefit than a risk.

3. The questions included on the assessment form did not include several key questions related to cognition and medication use. Relevant questions were noted to include resident overall mobility, falls history, bed rail use concerns such as a history of trying to climb out of bed when side rails were in place and if the resident had experienced any bed rail injuries or had become entangled in the past. However, when answered with either a "yes" or a "no", the form did not provide any direction to registered staff. The form included a question related to whether the resident was able to "state their preference about bed rails" and if the answer was "yes", the resident was required to answer whether they accepted the risks and if they were informed about the types of risk. The conclusion section of the assessment titled "Decision" did not include an option for the assessor to check that bed rails were "not recommended" and the reasons for the resident based on the outcomes of an observation period conducted by an interdisciplinary team of staff members. The registered staff member who completed many of the resident assessments reported that the assessments were indeed completed quickly just after admission, were based on the answers provided by the SDM (if available) and resident (if capable) and that many questions could not be accurately answered without getting to know the resident better. In addition, the registered staff member and the Director of Care reported that they felt pressured by the SDMs who insisted that a bed rail

be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation.

4. The assessment form did not specify what interdisciplinary staff members participated in the evaluation of the resident. The assessment forms reviewed included the name of the registered staff member only.

5. The written plan of care was reviewed for residents on the third floor after observing on June 3, 2016 one bed rail raised on beds in 12 different rooms. It appeared that the bed rails were left in the raised position out of staff habit. The raised bed rails were observed on the window side of each bed and in some cases covered by a blanket. No residents were observed in the beds at the time of observation. Discussion with the DOC revealed that staff were in some cases in 'the habit" of applying the bed rails and did not always follow the direction in the plan of care which identified that the bed rails be applied when the resident was in bed. According to the written plan of care for the above identified resident who became entangled, both bed rails were required to be raised when in bed. For resident #001 and #002, the plan of care stated that "2 bed rails were required for staff to provide instructions where to place hands on the bed rail for turning". With respect to the resident #003, the plan identified that the resident did not use the bed rails for any reason, yet both bed rails were required to be raised. According to the DOC, a number of residents had bed rails applied regardless of whether they could benefit from using them based on SDM request. In these cases, the term "safety" was included in the written plan of care as the reason for application. However, the term "safety" was not defined and was not included in the bed manufacturer's intended use instructions for the bed rail. It was not known what "safety" issues were being prevented by applying the bed rail.

This Order is being made based upon the application of three factors, (severity, scope and compliance history) in keeping with s.229(1) of the Long-Term Care Regulation 79/10. The severity of the non-compliance is 3 (actual harm), the scope of the non-compliance is 3 (wide spread - many residents with bed rails applied without a comprehensive bed rail safety assessment), and the compliance history is 3 (similar non compliance in the same area). The non-compliance was previously issued on May 12, 2015 as a Voluntary Plan of

Compliance. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

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 6th day of July, 2016

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